ORTHODONTIC ACQUAINTANCE CARD

PATIENT'S NAME _____ DOB _____ Sex: M F

Age _____ Weight _____ Height _____ Marital Status _____

Address _____ City _____ Zip _____

Phone # _____ Employed by _____ Occupation _____

Work Address _____ Work # _____

Patient's Dentist _____ Dentist's Phone # _____

Dentist's Address _____ City _____ Zip _____

Referred by _____ Do you have Orthodontic Insurance? Y N

If Yes, Name of Insurance _____ Address _____

If no, Name of responsible Party _____

Address _____ City _____ Zip _____

WHAT IS YOUR PRESENT DENTAL PROBLEM? _____

ARE YOU HAVING ANY DISCOMFORT OR PAIN? YES NO

IF YES, WHERE? _____

Date of last Dental Exam _____

MEDICAL HISTORY

Are you now or have you been in the last two years under the care of a physician?.....

Have you ever had any serious illness? ..... [ ] Yes [ ] No

Are you taking any medications (vitamins, cortisone (within past year), oral contraceptives, medicines, or drugs) at the present time? ..... [ ] Yes [ ] No

Have you ever had or been treated for heart trouble, rheumatic fever, abnormal blood pressure, thyroid, stomach ulcer, hay fever, asthma, allergies, sinusitis, diabetes, epilepsy, gall bladder, tuberculosis, kidney or liver involvements, joint problems, anemia, hysterectomy, blood disorder cancer, eye trouble. CIRCLE THE APPROPRIATE ONES.

Have you ever had any adverse effects from any anesthetics, antibiotics, or any other drugs?.... [ ] Yes [ ] No

DENTAL HISTORY

Have you ever had an acute sore mouth?..... [ ] Yes [ ] No

Do you have frequent fever blisters on your lips or mouth? ..... [ ] Yes [ ] No

Have you ever had burning of the tongue or crackling of the corners of your mouth?..... [ ] Yes [ ] No

Do your gums bleed_____When?..... [ ] Yes [ ] No

Are you aware of a bad taste in your mouth?..... [ ] Yes [ ] No

or odor in your mouth? ..... [ ] Yes [ ] No

Are you troubled with frequent gum boils? ..... [ ] Yes [ ] No

Do you grind your teeth at night? ..... [ ] Yes [ ] No

Does your jaw ever get "out of joint"?..... [ ] Yes [ ] No

Do you ever have pain opening or closing your mouth? ..... [ ] Yes [ ] No

Does your jaw ever "click"? ..... [ ] Yes [ ] No

Did you ever wear braces for straightening your teeth??..... [ ] Yes [ ] No

Have you had periodontal treatment? ..... [ ] Yes [ ] No

Are you bothered by tooth sensitivity? Hot? Cold? Sweets?..... [ ] Yes [ ] No

Signature_____ **Date**_____

EXAMINATION CHART

EXAM DATE _____

RE EXAM _____

RE EXAM _____

1. Profile: flat convex concave mild mod severe
2. Dentition: normal pro ret max mand bimax
3. Lips: normal parted everted
4. Symmetry: chin R L
5. Habits observed: TT MB LB_____
6. Hygiene_____ X per day P F G E
7. Soft tissue: normal gingivitis NUG
8. Frenum: normal enlarged max mand
9. Questionable lesions: none_____
10. Caries: low mod severe neglected
11. Teeth:

Right | Left

D- Decalcified
F. Fractured
C-Caries
S-Supernumerary
I-Impacted
O- Submerged
X-extracted
E-ectopic
M- Cong. Missing
A- Atypical or Malformed

12. Eruption time: normal early delayed
13. Prolonged retention of deciduous teeth:
14. Early loss of teeth: decid perm
15. Migrated: to mes dist
16. Class: I II III Div 1 2 mod severe

	R	L
Molar		
Cuspid		

Diagnosis:

17. Overbite: norm deep impinging open_____ mm
18. Overjet:_____ mm
19. Curve of Spee: flat mild mod severe
20. Midline diastema:_____ mm familial frenum
21. TMJ: norm clicks pain Limited movement
22. Path of closure: ant post R L
23. Cross bite: unilat R L bilat ant
24. Disharmony of arches: max wide narrow
    mand wide narrow
25. Midline_____|_____ mm
    mm
26. Crowding or rotations:
27. CO=CR
28. Attached Gingivae

RECOMMENDATIONS:

- ❑ Records and consult
- ❑ Recall
- ❑ Extractions
- ❑ Space maintainers
- ❑ No treatment

Fee for Exam _____ R&C _____ Estimated fee _____ Estimated treatment time _____

Other _____

_____

❑ Request x-rays from Dr. _____

Parent will: ❑ follow recommendations ❑ call back

Send letter(s) to source of referral _____ and/or Dr._____

Date	Service	Time	Next Treatment	Appt

Please fill out this form for insurance billing. It will help speed up the filing process. If your insurance does not have a unique ID#, we will need to have your Social Security #. All insurance companies, except for Metlife and Delta Dental issue you an ID card. Please bring that card along so we may make a copy for our files.

DENTAL INSURANCE INFORMATION

Patient Name_____ **Date**_____

1. **First & Last** name of **card holder**_____
2. **SS #** of card holder or **ID#** _____
3. **Date** of **Birth** of **card holder**_____
4. **Group #** and **Employer Name**_____
5. Address to send insurance claim to:_____

_____

If you have a **secondary** insurance, please provide the same information.

1. **First & Last** name of card holder_____
2. **SS #** of card holder or **ID#**_____
3. **Date** of **Birth** of **card holder**_____
4. **Group #** and **Employer Name**_____
5. Address to send insurance claim to:_____

_____

While we will make every effort to find out what your insurance benefits are, this is not a guarantee of payment from them. Ultimately payment is your responsibility.

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services -OR- ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preautohorization Number (INSURANCE)

CARDHOLDER

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) / /

14. Gender ☐ M ☐ F

15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number

17. Employer Name

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) / /

7. Gender ☐ M ☐ F

8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number

10. Relationship to Primary Subscriber (Check applicable box)
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box)
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) / /

22. Gender ☐ M ☐ F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	/ /							0.00
2	/ /							0.00
3	/ /							0.00
4	/ /							0.00
5	/ /							0.00
6	/ /							0.00
7	/ /							0.00
8	/ /							0.00
9								
10								

MISSING TEETH INFORMATION

34. (Place an "X" on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	125.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Parent/Guardian Signature Date

37. I hereby autohrize and direct payment of the dental benefits, otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)
☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00-99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics?
☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY) / /

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes(Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box)
☐ Occupational illness/injury ☐ Auto Accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedure

X _____
Signed (Treating Dentist) Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code 1223X0400X

57. Phone Number

58. Additional Provider ID

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Patient Acknowledgment

Patient Name(s): _____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

_____

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

Katsis Orthodontics
110 S. Oak Ave. Bartlett 130 N. Bloomingdale Rd., Bloomingdale 1213 West Joliet St., West Chicago
(630) 894-5557