SHIRCK Orthodontics

FOR OFFICE ONLY
Verified Patient Info _____

Medical History Information

Date _____

Patient Name _____Age _____ Birthdate _____

Street Address _____ Male _____ Female _____

City _____State _____Zip _____

Patients Cell _____ Carrier Verizon Sprint ATT Other_____

Fathers Name (for Minors) _____Cell# _____ Carrier Verizon Sprint ATT Other_____

Mothers Name (for Minors) _____Cell# _____ Carrier Verizon Sprint ATT Other_____

Family Dentist _____ List any family member seen by Shirck Orthodontics _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

☐ HEART TROUBLE	☐ HIV/AIDS	☐ ATTENTION DEFICIT DISORDER	☐ LIVER INVOLVEMENT
☐ MITRAL VALVE PRO	☐ ANEMIA	☐ KIDNEY PROBLEMS	☐ HEPATITIS
☐ HEART MURMUR	☐ EPILEPSY	☐ ENDOCRINE PROBLEMS	☐ BLOOD DISORDERS
☐ RHEUMATIC FEVER	☐ ASTHMA	☐ PROLONGED BLEEDING	☐ DIABETES
☐ PNEUMONIA	☐ FAINT/DIZZY	☐ TUBERCULOSIS	☐ OTHER_____

Does patient have tendency to: TMJ___ Ringing in the Ears___ Headaches/Migraines___? If yes, has patient been treated for these concerns and how? _____

Have tonsils and adenoids been removed?_____ If yes, at what age?_____

List any medications being taken and reason for _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY_____

Financially Responsible Party Information

Name _____ Relationship to Patient _____ Date of Birth_____

Address (if different from patient) _____

Cell Phone _____ Carrier Verizon Sprint ATT Other_____ Email _____

Dental Insurance Carrier Information

Member Name _____ Relationship to Patient _____ Date of Birth_____

Member Address (if different from patient) _____

Cell Phone _____ Carrier Verizon Sprint ATT Other_____ SSN#_____

Insurance Company _____ Member ID_____ Employer_____

In an effort to grow in our industry, we would love to hear all the ways in which you have heard about Shirck Orthodontics. We really appreciate your feedback!

Please place an "X" next to each of the WAYS in which you heard about us.

___ Insurance	___ Magazine Publication _____	___ Dentist _____
___ Internet	___ Friend/Family _____	___ Staff _____
___ Invisalign Website	___ School Sponsorship _____	___ Sport Event _____
___ Mailer/Postcard	___ Sport Banner _____	___ Community Event _____
___ Drive By/Saw Sign	___ Billboard, Where?_____	___ Radio_____

Signature_____ **Date**_____

SHIRCK Orthodontics

HIPAA OMNIBUS RULE PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name ❑ Nickname _____ ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS VIA:
(check all that apply)

❑ Text Message to my Cell Phone ❑ Email Confirmation

I AUTHORIZE INFORMATION ABOUT MY HEALTH, TREATMENT & BILLING INFORMATION BE CONVEYED VIA:
(check all that apply)

❑ Cell Phone ❑ Home Phone ❑ Work Phone

❑ Text Message to my Cell Phone ❑ Email

I GRANT PHOTOGRAPHY RELEASE PERMISSION to Shirck Orthodontics and its representatives, to take and use: photographs and/or digital images of the patient for use in news releases, social media, websites and educational materials as follows: printed publications or materials, electronic publications, or Web sites. I agree that the patient's name and identity: may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints and digital reproductions shall be the property of Shirck Orthodontics**:**

❑ YES ❑ NO

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office does not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent. The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PROTECTIVE HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Please print name of Patient: _____

Please sign Patient / Guardian of Patient: _____

NOTICE OF PRIVACY PRACTICES PRIVACY NOTICE

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

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

• To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);

• To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);

• To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;

• Internally, to all staff members who have any role in your treatment;

• To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;

• To your family and close friends involved in your treatment; and/or,

• We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

• Request restrictions on the use and disclosure of your protected health information;

• Request confidential communication of your protected health information;

• Inspect and obtain copies of your protected health information through asking us;

• Amend or modify your protected health information in certain circumstances;

• Receive an accounting of certain disclosures made by us of your protected health information; and,

• You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

• By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;

• To abide by the terms of our Privacy Notice that is currently in effect; and,

• To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

• Honor any request by you to restrict the use or disclosure of your protected health information;

• Amend your protected health information if, for example, it is accurate and complete; or,

• Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

Family Program

As a preventative orthodontic office, we like to examine the children in our patient's family by age 7 to take initial measurements, create baseline numbers and track growth patterns. Usually, no orthodontic treatment will be needed at this time and with that good news, Dr. Jeff and Dr. Jen will place your child in our Kids Club Program where they will continue to monitor their growth and development all at **no charge to you**! The Kids Club is a special Program just for our younger patients with fun prizes.

Early initial examination results will be sent to your general dentist. This allows us to work in partnership with you, your dentist and your child. If your child has not yet reached their **7th birthday**, we will keep their name in our system and when their **7th birthday** approaches, we will contact you regarding setting up their complimentary evaluation. **If you end up with two family members in treatment at the same time, you would also be eligible for a multifamily discount of 3%!**

Please print the name of the family member being seen for the New Patient Exam:
First: _____ Last: _____

List any family member you would like to receive an initial complimentary examination at age 7.			
Name- First & Last	**Date of Birth**	**Relationship**	**Address**
Additional family member over the age of 7 you would like to receive a complimentary examination in the near future; that includes you, Mom and Dad!			
Name- First & Last	**Date of Birth**	**Relationship**	**Address**

Welcome to our orthodontic family. It is our honor and privilege to provide you with the finest orthodontic care while creating your beautiful new smile!

Your Smile Makers at Shirck Orthodontics

SHIRCK
Orthodontics
your smile maker

At Shirck Orthodontics, we believe that a beautiful smile is not expensive. It's priceless.
We never want finances to get in the way of starting treatment and, in most cases, we are able to cater to your unique financial needs. Taking a moment to fill out this simple form will help us customize our financial options for you.

If treatment is deemed necessary, what is your ideal **initial** payment?

- $300 - $499
- $500-$749
- $750+
- I would like to pay in full to receive a pay in full courtesy. (4% cash/check or 3% credit card)
- I have a health/flexible savings account to use as well.

If treatment is deemed necessary, what is your ideal **monthly** payment?

- $100-$199
- $200-$299
- $300-$399
- $400-$499
- I have a health/flexible savings account to use as well.

We are thrilled you have chosen a consultation with our office. We can't wait to work with you and get your treatment started so that you can have the smile you've always wanted!

The Smile Makers at Shirck Orthodontics