

SOBLER ORTHODONTICS

PRACTICE LIMITED TO ORTHODONTICS

Full Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone _____ Mobile # _____
DOB: _____ Female Male
Dentist: _____ Last Cleaning: _____

Patient lives with (*please check all that apply*):

mother father stepmother stepfather grandmother grandfather other _____

Siblings (please list names & ages and if treated here): _____

Hobbies & interests: _____ School: _____

Whom may we thank for referring you to our office? _____

FATHER INFORMATION

Full name: _____ Preferred name: _____
Title: Mr. Dr. Rev. other _____ Cell Phone: _____
Home address (if diff.): _____ Home phone: (if diff.): _____
City/State/Zip (if diff.): _____ Work phone: _____
Employer: _____ Occupation/Position: _____

MOTHER INFORMATION

Full name: _____ Preferred name: _____
Title: Mrs. Ms. Miss Dr. Rev. other _____ Cell Phone: _____
Home address (if diff.): _____ Home phone: (if diff.): _____
City/State/Zip (if diff.): _____ Work phone: _____
Employer: _____ Occupation/Position: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Full name: _____ Preferred name: _____
Title: Mr. Mrs. Ms. Miss Dr. Rev. Other _____ Cell phone: _____
Home address (if diff.): _____ Home phone (if diff.): _____
City/State/Zip (if diff.): _____ Work phone: _____
Employer: _____ Occupation/Position: _____
Social Security # _____ Driver License # _____ State: _____

AUTHORIZATIONS AND RELEASES

- I consent to examination by Dr. Terry Sobler and authorize him to perform diagnostic procedures and treatments as may be necessary for proper orthodontic care.
- I authorize release of any information pertaining to my child's health care, advice, and treatments provided to third payers or to other health care practitioners.
- I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill services. I agree to be fully responsible for the total payment for procedures performed in this office, as well as for any necessary collection and attorney fees.
- I give permission for the use of photographs and records made in the process of examination and treatment to be used for the purposes of research, education, publication in professional journals.

Signature: _____ Relationship to Patient: _____ Date: _____

339 North Main Street, Suite 7-8 • New City, NY 10956 • (845) 634-3560

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CONFIDENTIAL

DATE _____

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone _____ Mobile # _____ DOB: _____

Female Male

Please rate the overall condition of your health: excellent good fair poor

Physician's Name	Specialty	Date of Last Visit	Reason for Visit
_____	_____	_____	_____
_____	_____	_____	_____

Dentist: _____ Last Prophy: _____

Have you been hospitalized or had surgery or any serious illness in the past 5 years? _____
If so, explain: _____

Has a physician ever told you to take special medication before dental work? _____

If so, why? _____

Are you currently taking any medications, pills drugs, herbs, or nutritional supplements? _____

If so, please list: _____

Do you use any tobacco products? _____ If so, what type? _____ How much? _____

(Girls- important for determination of skeletal maturity) Have you started your monthly period? _____ If yes, when? _____

Are you allergic to any of the following substances? (please list specific substances or reactions in the adjacent space)

- | | |
|--|--|
| <input type="checkbox"/> local anesthetics _____ | <input type="checkbox"/> metals _____ |
| <input type="checkbox"/> aspirin _____ | <input type="checkbox"/> latex _____ |
| <input type="checkbox"/> ibuprofen (Motrin, Advil) _____ | <input type="checkbox"/> acrylic _____ |
| <input type="checkbox"/> antibiotics _____ | <input type="checkbox"/> foods _____ |
| <input type="checkbox"/> codeine or narcotics _____ | <input type="checkbox"/> animals _____ |
| <input type="checkbox"/> other substances _____ | |

Do you currently have, or have you ever experienced, any of the following conditions or diseases?

- | | |
|---|--|
| <input type="checkbox"/> damaged heart valves, heart murmur, rheumatic fever, scarlet fever | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> prosthetic heart valve, prosthetic joint | <input type="checkbox"/> injury to head, neck, or back |
| <input type="checkbox"/> cardiovascular disease, high blood pressure, arterial sclerosis, stroke, heart attack, chest pain, shortness of breath, congestive heart failure | <input type="checkbox"/> arthritis, painful swollen joints, rheumatism |
| <input type="checkbox"/> blood disorders, anemia, hemophilia, sickle cell disease, prolonged bleeding, excessive bruising | <input type="checkbox"/> bone, muscle, or skin diseases |
| <input type="checkbox"/> allergies, asthma, hayfever, sinus trouble, anaphalaxis | <input type="checkbox"/> stomach ulcers, digestive system disorders or diseases |
| <input type="checkbox"/> liver disease, hepatitis, jaundice | <input type="checkbox"/> kidney trouble |
| <input type="checkbox"/> AIDS, ARC, HIV | <input type="checkbox"/> sexually transmitted diseases |
| <input type="checkbox"/> thyroid problems, endocrine disorders | <input type="checkbox"/> epilepsy, seizure disorders, neurological diseases |
| <input type="checkbox"/> respiratory problems, tuberculosis, bronchitis, emphysema | <input type="checkbox"/> cancer, cancer treatments, chemotherapy, radiation treatments |
| <input type="checkbox"/> fainting spells, low blood pressure | <input type="checkbox"/> immune system disorders, prolonged steroid treatments |
| <input type="checkbox"/> vision, hearing, or tasting problems, tonsils or adenoid conditions | <input type="checkbox"/> drug or alcohol abuse or addiction |
| <input type="checkbox"/> skin disorder | <input type="checkbox"/> mental health disturbance, behavioral problem |
| | <input type="checkbox"/> anorexia, bulimia |
| | <input type="checkbox"/> unexplained weight loss, poor appetite |
| | <input type="checkbox"/> headaches, migraines |
| | <input type="checkbox"/> birth defects, congenital disorder, syndrome |

Please explain any checked responses: _____

Do you have any disease, condition, or problem not listed above of which we should be aware? _____

If so, please explain: _____

In case of emergency, name of nearest relative not living with you: _____ Phone: _____

Signature: _____ Relationship to Patient: _____ Date: _____

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339 North Main Street, Suite 7-8, New City, NY 10956
TEL: (845) 634-3560 FAX: (845) 634-0619

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization

while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.25 for each page, \$20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dina Kennedy

Telephone: 845-634-3560

Fax: 845-634-0619

Address: c/o Dr. Terry Sobler, DMD, PC, 339 N. Main St., Ste. 7-8, New City, NY 10956

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes.

Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer: Dina Kennedy

Telephone: 845-634-3560

Fax: 845-634-0619

Address: c/o Dr. Terry Sobler, DMD, PC, 339 N. Main St., Ste. 7-8, New City, NY 10956

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of
Privacy Practices.

(Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please specify)
-
-
-

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PRACTICE LIMITED TO ORTHODONTICS

INSURANCE INFORMATION

PATIENT INFORMATION

Full Name: _____ Birthdate: _____

PRIMARY INSURANCE

Full name of insured: _____ Date of birth: _____
Home address : _____ Home phone: _____
City/State/Zip: _____ Work phone: _____
Social Security #: _____

Patient's relationship to insured : self spouse child other : _____

Name of employer providing insurance : _____
Employer address: _____
Employer City/State/Zip : _____
Name of insurance company : _____ Type of insurance: medical dental
Address: _____ Effective date: _____
City/State/Zip: _____ Phone number : _____
Group # _____ ID # _____

SECONDARY INSURANCE

Full name of insured: _____ Date of birth: _____
Home address : _____ Home phone: _____
City/State/Zip: _____ Work phone: _____
Social Security #: _____

Patient's relationship to insured : self spouse child other : _____

Name of employer providing insurance : _____
Employer address: _____
Employer City/State/Zip : _____
Name of insurance company : _____ Type of insurance: medical dental
Address: _____ Effective date: _____
City/State/Zip: _____ Phone number : _____
Group # _____ ID # _____

AUTHORIZATIONS AND RELEASES

I authorize release of any information relating to this claim to my insurance company.

Signature: _____ Date: _____