

Child Dental/Medical Health History Form

Patient's Name: _____ Date: _____
 (first) (middle) (last)

GENERAL

YES NO

- Does your child follow directions well?
- Does your child have a learning disability or need extra help with instructions?
- Is your child sensitive or self-conscious?
- Are you aware that some appointments will be during school / work hours?

Have there been any injuries to your child's face, mouth, teeth or chin?
 If yes, please explain: _____

Have any teeth been removed by extraction? If yes, please explain: _____

Has anyone else in your family received orthodontic treatment? If yes, how did they feel about the results? _____

DENTAL

YES NO

- Is your child presently in any dental pain?
- Has your child ever experienced an unfavorable reaction to dentistry?
- Has your child ever knocked out or chipped any teeth?
- Has your child ever been informed of extra or missing teeth?
- Is any part of your child's mouth sensitive to temperature or pressure?
- Does your child brush his / her teeth daily?
- Does your child floss regularly?
- Do your child's gums bleed when he / she brushes?
- Does your child predominantly breathe through his / her mouth?
- Does your child require any pre-medication for dental procedures?
- Does your child have any kind of finger / thumb or tongue habit?
- Has your child ever had any pain / tenderness in his / her jaw (TMJ / TMD)?
- Is your child aware of any jaw clicking or popping?
- Has your child been told that he / she clenches or grinds his / her teeth?
- Has your child ever experienced chronic ringing in his / her ears?
- Does your child have "tension" headaches?
- Does your child have any difficulty chewing or swallowing food?
- Does your child's bite feel uncomfortable?

What is your child's (or parent's) primary concern with his / her teeth? _____

Indicate your child's feelings / attitude towards having orthodontic treatment:

- Wants treatment Treatment is necessary
- Unwilling but agrees Uncooperative

Has an orthodontist been previously consulted? _____

Are you aware of any dental work that needs to be completed prior to orthodontic treatment? _____

Date of your child's most recent dental examination: _____

MEDICAL

YES NO

Has your child ever had any of the following diseases or medical conditions?

- Abnormal Bleeding / Hemophilia
- Anemia
- Arthritis
- Asthma or Hayfever
- Blood Disorders
- Congenital Heart Defect
- Depression/Mental Illness
- Diabetes
- Dizziness
- Epilepsy
- Gastrointestinal Disorders
- Heart Problems
- Heart Murmur
- Hepatitis / Liver Problems
- Herpes
- High Blood Pressure
- HIV+ / AIDS
- Kidney Problems
- Pneumonia
- Prolonged Bleeding
- Radiation / Chemotherapy
- Rheumatic Fever
- Tuberculosis
- Tumor or Cancer

Does your child have any other medical conditions not described above?
 If yes, please explain: _____

(continued...)

YES NO Is your child allergic to any of the following?

- Penicillin
- Erythromycin
- Dental Anesthetics
- Aspirin
- Tetracycline
- Codeine
- Metal / Jewelry

Has your child ever had to take antibiotics prior to a dental visit / checkup? _____

Has your child been diagnosed with any emotional disorders, including ADD / ADHD? If yes, please list any medications: _____

Please list any other medications to which your child has had an allergic reaction: _____

Please list all medications that your child is currently taking: _____

Is your child currently under the care of a physician? If yes, please explain: _____

Please explain any medical problems that your child has had in the past: _____

I have read and I understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes to this history record or medical / dental status.

We will discuss your treatment with parents / legal guardians / the person financially responsible for your treatment / referring Doctor / Dentist for the the furtherment of your treatment.

Signature of parent / legal guardian Date

Medical History Updates or Changes

Date: _____ Date: _____ Date: _____

Comments: _____ Comments: _____ Comments: _____

Signature: _____ Signature: _____ Signature: _____

Thank you for filling out this form completely. It will enable us to help you more effectively. Please do not hesitate to ask any questions; we are always happy to help.



PATIENT INFORMATION
(PLEASE COMPLETE ALL FIELDS THAT APPLY)

Today's date _____

Patient's Name _____
(First) (Middle) (Last)

Email _____ Birth date _____

SS # _____ Age _____ Sex _____

Home Address _____ how long at this address? _____

City _____ State _____ Zip _____

Phone _____ Mobile # _____

Wk Phone _____ May we contact you at work? Y N

Employer _____ Occupation _____

Years employed? _____

Patients spouse information

Spouse Name _____

Birth date _____ SS # _____

Employer _____

Occupation _____ Years employed? _____

Mother's information

Name _____
(First) (Middle) (Last)

Email _____ Birth date _____

SS # _____ Marital Status M S W D

Home Address _____ How long at this address _____

City _____ State _____ Zip _____

Phone Number _____ Mobile # _____

Wk Phone _____ may we contact you at work? Y N

Employer _____ Years employed? _____

Occupation _____ Stepfather name _____

(OVER)

Father's Information

Name _____
(First) (Middle) (Last)

Email _____ Birth date _____

SS # _____ Marital Status M S W D

Home Address _____ How long at this address? _____

City _____ State _____ Zip _____

Phone Number _____ Mobile # _____

Wk Phone _____ may we contact you at work? Y N

Employer _____ Years employed? _____

Occupation _____ Stepmother name _____

Insurance

Primary Insurance _____ Cardholder _____ SS# _____

Primary Insurance _____ Cardholder _____ SS# _____

Other Insurance _____ Cardholder _____ SS# _____

Emergency contact information

(Name) (Phone #) (Relationship)

(Name) (Phone #) (Relationship)

General Dentist _____

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

I undersigned accept financial responsibility for the above patient. A finance charge of \$15.00 dollars will be assessed on accounts over 30 days past due. I/we authorize the release of any dental information required to process insurance claims. I/our signatures may be used for that purpose. Copy of this authorization is as valid as the original.

Patient _____ Date _____
(18 years or older)

Mother _____ Date _____

Father _____ Date _____

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email address, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent.

Thank You for your cooperation. Please let us know if you have any question.

Print Patient Name

Date

Patient's Signature (If 18yrs or older)

Parent, or legal Guardian signature

Copus Orthodontics
Dr. David Copus DDS MS PC
4131 Shrestha Dr.
Bay City, MI 48708
989-667-5980

**IDENTITY THEFT DETECTION AND RESPONSE
POLICY AND PROCEDURES FOR COPUS
ORTHODONTICS**

I. Policy

This office has adopted an Identity Theft Detection and Response Policy and Procedures Program ("Program") pursuant to the Federal Trade Commission's Red Flag Rules ("Rules"). The purpose of the Program is to assist in detecting, preventing, and mitigating instances of possible identity theft in connection with patients in our practice. It does so by (a) requiring us to verify the identity of all new patients, (b) establishing certain "Red Flags" that could indicate possible identity theft, and (c) requiring follow up on any incident which triggers a Red Flag. The Program must be observed by all employees of this practice, including the professional, administrative, and clerical staff,

II. Red Flags that May Indicate Identity Theft:

1. An individual falsely claiming to be someone else who is known to the office staff;
2. Unexplained discrepancies between the patient's medical records and the patient's physical condition.
3. A discrepancy between the address contained in the patient's consumer credit report and the address provided by the patient; [include this in your program only if the practice obtains credit reports in connection with providing patient services]
4. A report by a patient known to the office staff that he or she has been the victim of identity theft in connection with oral health care services provided by the practice;

III. Responding to Red Flags

Any employee of this practice who encounters a Red Flag situation or any other activity that may indicate identity theft should report the situation to Dr. David Copus and staff. That person/s will follow up as appropriate and will record the incident and its handling in a Red Flags Log kept in this office.

Possible responses to a Red Flag Situation include the following:

a. Patient notification

The practice may notify the patient if a Red Flag is encountered that involves that patient's identity. Notification may be provided by mail, by telephone, or in-person – as the practice deems appropriate. The notification may include verification that the patient has not been victimized by identity theft in connection with any visits to the practice.

In some instances, additional specific action will be required:

- If notice of an actual identity theft is received, we will immediately cease any collection efforts that are related to the identity theft.

If a consumer credit report contains an address different from the address provided by the patient, the correct address will be verified with the patient. If

- the verified address is different from the address in the credit report, we may report the verified address to the credit reporting agency.

b. Notification of Legal Authorities

If the practice obtains specific information pertaining to a person committing identity theft, we will provide that information to law enforcement to the extent permitted under HIPAA and other privacy rules. We may seek advice of legal counsel on the issues involved.

Of course, if a Red Flag is triggered but we determine that there clearly has been no identity theft, no action will be taken.

IV. Plan Administration and Updates

All employees of this practice will receive a copy of this Policy and will be instructed as to its procedures. We will ask each employee to sign an acknowledgement of receipt and understanding. We will evaluate our Program annually and update it in light of experience. Any questions about this Policy should be addressed to Dr.David Copus and Staff.

IMPORTANT NOTE: While this model Policy attempts to provide dentists with the tools needed to comply with the Red Flag Rules, it has not been approved by the Federal Trade Commission ("FTC"). It should not be treated or considered as legal advice or as applicable to each dental practice. Rather, each practice should adapt this model Policy in light of its own experience and the advice that it receives from its counsel. We will provide updates as new information becomes available.

ACKNOWLEDGEMENT

I, _____, have read the practice's Identity Theft Detection and Response Policy and Procedures and understand the contents. I have been instructed regarding situations that may suggest possible identity theft as described in the Identity Theft Detection and Response Policy and Procedures. If I discover a possible instance of identity theft, I will immediately bring the matter to the attention of Dr.David Copus and staff.

Signature of responsible party:

Date _____