Orthodontics of Cambridge

William U. Murthy, DMD, Captain

Diplomate, American Board of Orthodontics
Captain, U.S. Air Force, Dental Corps, Veteran

Specialist in Orthodontics for Children & Adults

1 About You

Today's Date: ___/___/_____

E-mail address: _____

Name: _____
Last First MI Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

Birthday: ___/___/_____ Age: _____

Home Address: _____
APT/CONDO#

_____
City State ZIP

Primary Phone #: (_____)_____

Secondary Phone #: (_____)_____

Employer:_____

Employer's Address: _____

How long there: _____ Occupation: _____

Where & when are best to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last visit date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Phone #: _____Birthday: ___/___/_____

Person Responsible for Account: _____

Relation: _____ Phone #: (_____)_____

Billing Address: _____

Employer: _____

3 Orthodontic Insurance

Primary

Orthodontic Coverage: ☐ Yes ☐ No

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Subscriber's ID #: _____

Group # (Plan, Local or Policy #): _____

Subscriber's Name: _____

Subscriber's Birthday: ___/___/_____

Subscriber's Employer: _____

Secondary

Orthodontic Coverage: ☐ Yes ☐ No

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Subscriber's ID #: _____

Group # (Plan, Local or Policy #): _____

Subscriber's Name: _____

Subscriber's Birthday: ___/___/_____

Subscriber's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____

Relation: _____

Phone #: (_____)_____

CONTINUED ON BACK

Transforming Smiles Since 2006

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www.OrthodonticsOfCambridge.com E-mail: office@OrthodonticsOfCambridge.com

Member American Association of Orthodontists®

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:_____

Phone #: (_____)_____ Date of last visit: _____/_____/_____

Your current physician health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

For women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following disease or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	Anemia	Y	N	Hepatitis
Y	N	Artificial Bones/Joint/Valves	Y	N	High/Low Blood Pressure
Y	N	Asthma / Arthritis	Y	N	HIV+ / AIDS
Y	N	Blood Transfusion	Y	N	Hospitalized for any reason
Y	N	Cancer / Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug/ Alcohol Abuse	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Severe/ Frequent Headaches
Y	N	Epilepsy /Seizures /Fainting	Y	N	Shingles
Y	N	Fever Blisters / Herpes	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Heart Attack / Stroke	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers / Colitis
Y	N	Heart Surgery / Pacemaker	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Any Metals /Plastics	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any other drugs / materials that you are allergic to:

_____

5 Dental History

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: Good Fair Poor

Do you like your smile? ☐ Yes ☐ No Gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems? _____

Do you generally breath through your mouth? ☐ Yes ☐ No

If yes, please circle: While awake? While Asleep?

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____ Date: _____/_____/_____

OFFICE USE ONLY *OFFICE USE ONLY* **OFFICE USE ONLY** *OFFICE USE ONLY*

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: ____/____/_____

Doctor's Comments: _____

_____

_____

_____

_____

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Initial Records Consent Form

I, _____, authorize and consent Orthodontics of Cambridge to take diagnostic orthodontic records including facial photos and intra-oral photos at no charge to me.

I understand that it is also recommended for Orthodontics of Cambridge to take a panoramic x-ray and a lateral cephalometric x-ray which will allow Dr. Murthy to better determine an accurate diagnosis and customized treatment plan to be discussed at my consultation visit. If I wish to have x-rays taken today, an appropriate charge of $125 per film ($250 for both) will be applied and due today. Once I have paid for the films they are my property and I can request to have a digital copy sent to me directly. If I choose to have films taken, any payments made today will be applied as a balance forward towards my active treatment fee upon the start of my orthodontic treatment with Orthodontics of Cambridge.

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.

_____
(Please 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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PATIENT ACKNOWLEDGEMENT & AGREEMENT REGARDING E-MAIL COMMUNICATION

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient/Parent E-mail: _____

Patient/Parent Signature:_____ Date:_____

Your Health Information Rights

Although your health record is the physical property of the facility that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to Orthodontics of Cambridge PC in writing.

Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. Orthodontics of Cambridge PC will provide the first accounting to you in any 12-month period without charge. The cost for subsequent requests for an accounting within the 12-month period will be no charge. We ask that you submit these requests in writing.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing.

Except under specific circumstances, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or is required by law. We must agree to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the information pertains solely to a health care item or service for which we have been paid by you out-of-pocket, and in full.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling (617) 864-2003 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be also submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: Dr. William Murthy

Telephone Number: (617) 864-2003

Orthodontics of Cambridge PC

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Cambridge, MA 02138
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Health Insurance Portability and Accountability Act of 1996

Notice of Privacy Practices

Effective April 14, 2003

Last Modified: February 5, 2013

NOTICE OF PATIENT PRIVACY PRACTICES

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

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

Orthodontics of Cambridge PC is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the main reception area and on our website at orthodonticsofcambridge.com. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice and we request that you acknowledge receipt with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be made available to anyone who asks for it, and be posted in the main reception area and on our website at orthodonticsofcambridge.com. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile.

We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include Practice Management. If these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract., In addition, business associates are individually required to abide by the HIPAA Rules.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency situation), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, information on health-related benefits or services; to remind you that you have an appointment for medical care; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials, please contact our Privacy Officer.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law. We may use and disclose health information to the following types of entities, including but not limited to:

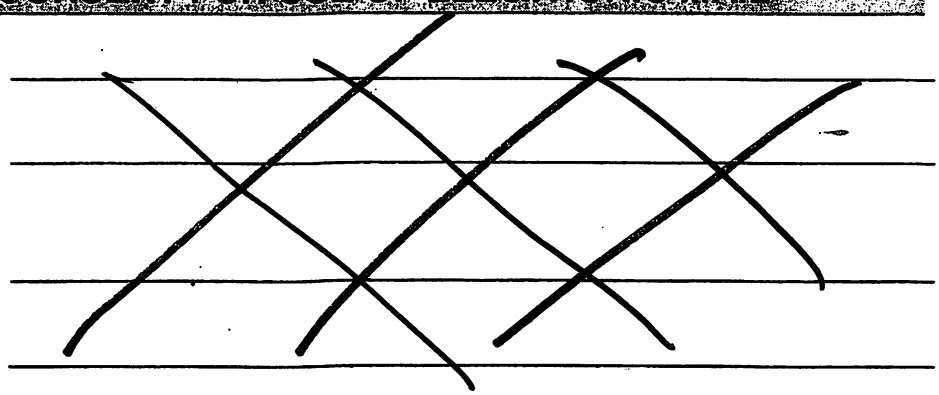
- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting, including population-based activities relating to improving health or reducing health care costs.

Orthodontics of Cambridge PC

PATIENT CONSENT FOR USE OF ELECTRONIC MAIL



1. RISK OF USING E-MAIL

Orthodontics of Cambridge offers patients the opportunity to communicate with clinicians by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before giving consent. These risks include, but are not limited to:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.

b. E-mail can be immediately broadcast worldwide and be received by both intended and unintended recipients.

c. E-mail senders can misaddress e-mail.

d. E-mail can be more easily falsified than handwritten or signed documents.

e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.

f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.

g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

h. E-mail can be used to introduce viruses into computer systems.

i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Orthodontics of Cambridge will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Orthodontics of Cambridge cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel will have access to those e-mails.

b. Orthodontics of Cambridge may forward e-mails internally to Orthodontics of Cambridge's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Orthodontics of Cambridge will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.

c. Although Orthodontics of Cambridge will endeavor to read and respond promptly to e-mail from the patient, Orthodontics of Cambridge cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time-sensitive matters.

d. If the patient's e-mail requires or invites a response from Orthodontics of Cambridge, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, issues of abuse, developmental disability, or substance abuse.

f. The patient is responsible for informing Orthodontics of Cambridge of any types of information the patient does not want to be sent by e-mail, in addition to those set out in (e) above.

g. The patient is responsible for protecting his/her password or other means of access to e-mail. Orthodontics of Cambridge is not liable for breaches of confidentiality caused by the patient or any third party.

h. Orthodontics of Cambridge shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

i. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Limit or avoid use of his/her employer's computer.

b. Inform Orthodontics of Cambridge of changes in his/her e-mail address.

c. Put his/her name in the body of the e-mail.

d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing questions).

e. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to the Provider.

f. Inform Orthodontics of Cambridge that the patient received e-mail from Orthodontics of Cambridge.

g. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.

h. Withdraw consent only by e-mail or written communication to the Provider.