***ALL PAGES ARE DOUBLE SIDED**

Cape Cod Braces
429 South Street, Hyannis, MA 02601
6 Nells Way, Orleans, MA 02554
1 Technology Park Drive, Bourne, MA 02532
508-771-1415
info@capecodbraces.com

Patient Information (Confidential)

PATIENT

Patient Name(First, Last): _____Prefers to be called: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Phone Number: (_____) _____ Date of Birth: _____/_____/_____ Gender: Male / Female

How did you hear about us? Patient / Other: _____

Who is accompanying patient at this visit? _____ Do you have legal custody? Y / N

PARENT / LEGAL GUARDIAN INFORMATION

Custodial parent(s) name(s): _____

☐ **Father/Mother** ☐ **Step Father/Step Mother** ☐ **Guardian**

Last Name: _____ First Name: _____

SSN#: _____ - _____ - _____ Date of Birth: _____ /_____ /_____

Home Phone Number: (_____) _____ Cell Phone Number: (_____) _____

Occupation: _____ Employer: _____

Email Address (we offer email appointment confirmations): _____

☐ **Father/Mother** ☐ **Step Father/Step Mother** ☐ **Guardian**

Last Name: _____ First Name: _____

SSN#: _____ - _____ - _____ Date of Birth: _____ /_____ /_____

Home Phone Number: (_____) _____ Cell Phone Number: (_____) _____

Occupation: _____ Employer: _____

Email Address (we offer email appointment confirmations): _____

Dental Insurance Information

Subscriber Name: _____ Relationship to Patient: _____

Primary Dental Insurance Company: _____ Employer:
_____

Subscriber SSN#: _____ - _____ - _____ Subscriber ID #: _____

Group Number: _____ Subscriber Date of Birth: _____ /_____ /_____

<u>If MassHealth:</u>

Patient Name: _____ MassHealth ID #: _____

Medical History

PATIENT NAME_____ Date of Birth: _____ /_____ /_____

Is the patient currently under physician's care: ☐ YES ☐ NO Date of Last Visit:_____ /_____ /_____

Physician's Name: _____ Phone Number: (_____) _____

Are all immunizations current: ☐ YES ☐ NO

Have you ever been hospitalized: ☐ YES ☐ NO If yes, reason: _____

Are you currently taking medications, if yes please list:

_____

Have you ever taken/had ☐ Fosamax ☐ Boniva ☐ Actonel ☐ Bisphosphonates ☐ Chemotherapy ☐ N/A

Women: Are you : ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ N/A

Any Allergies: ☐ N/A

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Nickel ☐ Sulfa Drugs

☐ Local Anesthetics ☐ Others not listed: _____

Please check any conditions you may have below: ☐ N/A

☐ AIDS/HIV	☐ Cancer	☐ Liver/Kidney Disease	☐ Prolonged bleeding
☐ Anemia	☐ Heart Issues/Murmur	☐ Steroid Therapy	☐ Epilepsy
☐ Tuberculosis	☐ Diabetes	☐ Emotional/Psych Disorder	☐ Cerebral Palsy
☐ Asthma	☐ Learning Disabilities	☐ Speech problems	☐ Seizures
☐ Rheumatic Fever	☐ Fainting	☐ High Blood Pressure	☐ Radiation Treatment
☐ Breathing Problems	☐ Hepatitis	☐ Hearing Loss	☐ Thyroid Disease

☐ OTHER: _____

Dental History

Has the patient been to the Dentist before: ☐ YES ☐ NO Where: _____

Date of Last Visit: _____ /_____ /_____ Is your water fluoridated: ☐ YES ☐ NO

Do you use Fluoride toothpaste: ☐ YES ☐ NO Mouth Rinse: ☐ YES ☐ NO

Does patient have or ever had braces: ☐ YES ☐ NO Do you want information about braces: ☐ YES ☐ NO

Do you have any of the following:

☐ Sensitivity to hot or cold ☐ Sensitivity to sweet ☐ Sensitivity to biting ☐ Bleeding Gums ☐ Swollen face or mouth

☐ Pain in any of your teeth ☐ Loose Teeth ☐ Problems with previous dental care:

_____

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGES IN MY HEALTH, I WILL INFORM MY DOCTOR AT THE NEXT APPOINTMENT

_____

Patient/Parent/Guardian Signature **Date**

_____

Doctor Signature **Date**

Please make note if there are any changes from your previous information

Date:_____ No Change:_____ Field Where Change Applies: _____ Initials _____

Date:_____ No Change:_____ Field Where Change Applies: _____ Initials _____

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APPOINTMENT CANCELLATIONS

As a courtesy, we make every effort to confirm your appointment one day in advance. However, it should be noted it is your responsibility to keep all appointments. We request a MINIMUM OF 24 HOURS to change or cancel an appointment. A fee may be incurred for all failed or late cancellations. For more than two failed or cancelled appointments you may be placed on same day only appointment basis.

MassHealth Patients: In keeping with MassHealth's policy regarding repeated failures to show for scheduled appointments, we will be notifying MassHealth of your appointment experiences, which may negatively affect your coverage status and continued inclusion in the MassHealth program.

DENTAL INSURANCE

If you have insurance coverage our team, as a courtesy, does their best to determine a proper **ESTIMATE** for you. Due to the many insurance companies and plans we cannot always predict the actual payments your insurance carrier will make. You are required to make payment of your full estimated responsibility upon services rendered. After payments are received from your insurance carrier, you may be required to make additional payments, have a credit issued to your account for future services or may be eligible for a refund. By signing this form, I hereby authorize and direct payment of dental benefits from my insurance company to Cape Cod Braces.

If you have Masshealth coverage, please be aware if you have a lapse in your coverage, or a procedure is denied, you are responsible for any out of pocket expenses that incur. You are responsible for understanding the benefits provided to you.

AUTHORIZATION AND RELEASE

I certify that the information provided is accurate and complete to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child during the period of such dental care to third party payers and/or health practitioners.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read/received a copy of this office's Notice of Privacy Practices.

_____

Patient/Parent/Guardian Signature **Date**

_____

Patient Name

PATIENT NAME_____

SOCIAL MEDIA CONSENT

We like to show off all the fun and great things that happen at Cape Cod Braces. Often times we do this on social media in the form of photographs or videos and include our patients and their families. Please let us know if we have your permission to post any photographs or videos that may include you or your child on various Cape Cod Braces social media sites. These may include (but are not limited to) Facebook, Google+, Twitter, and Instagram.

Please initial below

I consent to Cape Cod Braces social media usage [_____]

I do not consent to social media usage [_____]

ELECTRONIC COMMUNICATIONS ENCRYPTION WAIVER

When communicating via electronic media (e.g. email) HIPAA standards require us to utilize encryption technology for your privacy. To keep electronic communications private, we utilize third party encryption methods that typically require a password for viewing. If you prefer to avoid encrypting any emails that may contain private information and opt out of data encryption, please fill out the form below.

Please initial below

I authorize electronic encryption [_____]

I wish to opt out of electronic encryption [_____]

_____

Patient/Parent/Guardian Signature **Date**

HIPAA Patient Consent Form

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form is used to obtain authorization to release Protected Health Information regarding the following patient:

Patient Name: _____

I understand that I, or my child, have/ has certain rights to privacy regarding my/ his/ her protected health information. These rights are given to me/ him/ her under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Cape Cod Braces, and its employees (collectively known as "Cape Cod Braces") to use and disclose my protected health information to carry out:

1. Treatment (including treatment by other healthcare providers involved in my treatment).
2. Payment collection from third party payers (i.e. insurance companies).
3. The day to day healthcare operations of the practice.
4. Educational and demonstrational activities.

I understand that Cape Cod Braces reserves the right to change the terms of this notice from time to time and that I may contact Cape Cod Braces at any time to obtain a more current copy of this notice. I understand that I have the right to request restrictions on how my or my child's protected health information is used and disclosed to carry out treatment, payment, health care operations, and educational and demonstrational activities.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize Cape Cod Braces to disclose my/ my child's Protected Health Information to the following people:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

_____	_____
Responsible Party Name (Print)	Responsible Party Signature Date

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