PATIENT INFORMATION Date: _____

Patient's Name: _____ Sex: _____ Marital Status: _____
S.S.# _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____
Cell Number: _____
Email address: _____

Name of nearest relative/friend not living with you: _____
Phone #: _____ Address: _____
City: _____ State: _____ Zip: _____

Physician: _____ Dentist: _____

Please list what you feel is wrong with your teeth: _____

_____

Referred by: _____

EMPLOYMENT INFORMATION - SELF

Occupation: _____ Employed By: _____
Work Address: _____
City: _____ State: _____ Zip: _____

Spouse's Occupation: _____ Employed By: _____
Work Address: _____
City: _____ State: _____ Zip: _____

INSURANCE INFORMATION:

Do you have orthodontic insurance: _____
Name of primary insurance company: _____
Insured: _____ Relationship to insured: _____
S.S.#: _____ ID#: _____ Group No: _____
Date of birth of insured: _____ Ins. Mailing Address: _____
City: _____ State: _____ Zip: _____
Insurance Phone Number: _____

Secondary insurance company: _____
Insured: _____ Relationship to insured: _____
S.S.#: _____ Policy No: _____ Group No: _____
Date of birth of insured: _____ Ins. Mailing Address: _____
City: _____ State: _____ Zip: _____
Insurance phone number: _____

MEDICAL HISTORY: (circle yes or no and fill in the blanks where required)

1. Is the patient in good health? ..... No Yes
2. Have tonsils and/or adenoids been removed? At what age? ..... No Yes
3. Frequent colds, sore throats, or ear infections? ..... No Yes
4. Any history of major illness? If yes, list _____ No Yes
5. Any allergies or drug sensitivity? If yes, list _____ No Yes
6. Taking medication now? If yes, list _____ No Yes
7. Under medical care now? Reason _____ No Yes
   _____
8. Circle any of the following for which the patient has been treated:

Hepatitis	Convulsions	Emotional Problem	Fainting	Pregnancy
Diabetes	Asthma	Prolonged Bleeding	Tonsillitis	
Arthritis	Epilepsy	Nervous Disorders	Brain Injury	
Glaucoma	HIV	Rheumatic Fever	Endocrine Problems	
Tuberculosis	Heart Trouble	Kidney	Urinary Tract	

9. Does the patient have any special problems not listed above (pregnancy, etc.)? ... No Yes
   If yes, explain: _____

DENTAL HISTORY (circle answer)

1. Date of last dental exam _____ is work completed? _____ No Yes
2. Have there been any injuries to the face, mouth, or teeth? ..... No Yes
3. Has patient ever sucked thumbs or fingers? Until what age? _____ No Yes
4. Has patient ever had oral habits, such as lip biting or tongue thrusting? ..... No Yes
5. Does patient have any speech problems? ..... No Yes
6. Has patient ever had any speech therapy? ..... No Yes
7. Is the patient a mouth breather while asleep or awake? ..... No Yes
8. Are you aware of any missing or extra permanent teeth? ..... No Yes
9. Has anyone in the family had orthodontic treatment? ..... No Yes
10. Would you consider the patient's diet high in sweets? ..... No Yes
11. List any musical wind instruments played ..... No Yes
12. What are you and your dentist most concerned about? _____
    _____
13. Other comments: _____
14. Has this patient had any orthodontic treatment performed previously? ..... No Yes
    If yes, please indicate type and extent of the treatment _____
    _____

I give my permission to talk to the following persons listed below in regards to my account, insurance and orthodontic treatment:

_____ _____

I acknowledge full responsibility for all charges incurred regardless of insurance coverage. A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be assessed to all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me , by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or his/her assignee. I further agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 40% if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home on my cell or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and /or results on my answering machine or with a family member.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted. I acknowledge that I have received a copy of this office's Privacy Polices. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____
Patient or Authorized Person's Signature

Privacy Policy Notice
For Dr. Charles B. Jackson, Jr., D.D.S., M.S.D., P.C.

669 E. Union Square	2964 W 4700 S #103	2200 E 4500 S #250
Sandy, UT 84070	WVC, UT 84118	Holladay, UT 84117
801-571-1231	801-571-1231	801-278-5822

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.

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 payors 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;
- 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 inquires 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 Policy that is currently in effect;
- To advise you of our right to change the terms of this Privacy Policy 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 Policy.

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 overhead by other patients and third parties.

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

PATIENT/GUARDIAN ACKNOWLEDGMENT

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED A COPY OF THE PRIVACY POLICY.

_____ _____
Patient or Guardian signature Date

In case you do not agree to sign this form, our office must indicate why you declined to do so.

Reason for patient's refusal:

_____
_____
_____
_____

Privacy Director's signature _____ Date_____