VALLEY ADVANCED
ORTHODONTICS

Welcome,

Thank you for choosing Valley Advanced Orthodontics and welcome to our practice. We look forward to developing a professional relationship with you based on the highest quality of dental care.

Please complete the enclosed paperwork and return it to our office electronically at your earliest convenience. This information must be received prior to your appointment so that we have adequate time to enter your health history, dental history, and insurance information into our system. If we do not receive your completed forms prior to your appointment, you may be asked to reschedule.

For your appointment to proceed as efficiently as possible, please follow these instructions:

- please arrive **10 minutes prior to your scheduled appointment** to complete the check-in process
- please bring your **insurance card**, as well as **photo ID** and have them ready to scan

**If we do not have your insurance information prior to your appointment time you may be asked to reschedule.*

- It is our policy to collect any estimates, co-insurances, and deductibles **at the time of service.**

Please contact our office with any questions or concerns at 717-963-3003.

We look forward to meeting you soon!

Respectfully,

Treatment Coordinator

VALLEY ADVANCED ORTHODONTICS

PATIENT REGISTRATION

CONTACT INFORMATION

Dr. Mr. Mrs. Ms. _____ Preferred Name _____ Sex: M / F
(Last) (First) (initial)

Cell # ( ) _____ Home # ( ) _____ Work # ( ) ____-_____ Ext ( )

Social Security# _____ Email Address _____

Preferred Number ☐cell ☐home ☐work Marital Status _____ Spouses' Name _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer _____ Occupation _____

Emergency Contact_____ Emergency Contact #( )_____
(Last) (First)

REFERRAL INFORMATION

How did you find out about our office? _____

Who may we thank for referring you to our practice? _____

Reason for choosing she Dental Specialty Cetner?_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Name _____ Sex: M / F Relationship to Patient_____
(Last) (First) (initial)

Address _____
Street City State Zip Code

Cell#_____ Home#_____ Work#_____ Ext____ Email _____

INSURANCE INFORMATION

Primary Carrier

Insured Name _____

Birthday _____

Insured's Employer _____

Insured Soc. Sec. # _____

Group # _____

Insurance Company _____

Insurance Co. Address _____

_____

Insurance Co. Phone # _____

Secondary Carrier (If you have double coverage)

Insured Name _____

Birthday _____

Insured's Employer _____

Insured Soc. Sec. # _____

Group # _____

Insurance Company _____

Insurance Co. Address _____

_____

Insurance Co. Phone #_____

Our goal is to provide you with extraordinary care and service. Is there anything we can do to give you the best experience?

_____

_____ Date _____ Relationship to Patient _____

Signature of patient, parent or guardian

VALLEY ADVANCED ORTHODONTICS

PATIENT MEDICAL RECORD

Dr. Mr. Mrs. Ms. _____ Date of Birth _____
(Last) (First) (initial)

What is your general state of health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

◊Primary Physician
Name_____
Address _____
Phone #_____

◊Specialist (type)_____
Name_____
Address _____
Phone #_____

◊Specialist (type)_____
Name_____
Address _____
Phone #_____

Have you been under a physician's care during the last two years?_____
Have you been treated in a hospital in the past three years?_____
Have you had major surgery?_____
History with general or IV anesthesia?_____
Have you ever taken drugs for osteoperosis/penia?_____
If female: Are you pregnant or nursing?_____
Do you have any food allergies?_____
Has it ever been recommended that you take antibiotics prior to dental visits?_____

Do you or have you had any of the following below?

	Present	Past	None
Heart Disease	☐	☐	☐
Heart Failure	☐	☐	☐
Angina	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Congenital Heart Lesion	☐	☐	☐
Artificial Heart Valves/ Stent	☐	☐	☐
Heart Surgery	☐	☐	☐
Pacemaker	☐	☐	☐
High Blood Pressure	☐	☐	☐
Stroke	☐	☐	☐
Diabetes	☐	☐	☐
Bleeding Problem / Bruises	☐	☐	☐
Hemophilia	☐	☐	☐

	Present	Past	None
Anemia / Sickle Cell	☐	☐	☐
Leukemia	☐	☐	☐
HIV+ / AIDS	☐	☐	☐
Fainting/Dizzy Spells	☐	☐	☐
Lung Disease	☐	☐	☐
Asthma	☐	☐	☐
Emphysema / Bronchitis	☐	☐	☐
Tuberculosis / PPD+	☐	☐	☐
Cancer	☐	☐	☐
Radiation Therapy	☐	☐	☐
Chemotherapy	☐	☐	☐
Kidney Disease	☐	☐	☐
Liver Disease	☐	☐	☐
Hepatitis A,B	☐	☐	☐
Hepatitis C	☐	☐	☐

	Present	Past	None
Acid Reflux / GERD	☐	☐	☐
Stomach Ulcer	☐	☐	☐
Autoimmune Disease	☐	☐	☐
Thyroid Disease	☐	☐	☐
Fibromyalgia	☐	☐	☐
Arthritis	☐	☐	☐
Osteoporosis/Penia	☐	☐	☐
Psychiatric Disorder	☐	☐	☐
Epilepsy / Seizures	☐	☐	☐
Cerebral Palsy	☐	☐	☐
Penicillin Allergy	☐	☐	☐
Codeine Allergy	☐	☐	☐
Novocain Allergy	☐	☐	☐
Aspirin Allergy	☐	☐	☐
Sulfa Allergy	☐	☐	☐
Latex Allergy	☐	☐	☐
	☐	☐	☐

Do you have any condition, disease or problem not previously listed?_____
Are you allergic to any medications not listed above? If so which:_____
Please list all the medications you are taking, including over the counter drugs and herbs:

Medications	Dosage / Day	Reason

Signature of patient/parent/guardian _____ Date_____

VALLEY ADVANCED ORTHODONTICS

DENTAL HEALTH RECORD

Dr. Mr. Mrs. Ms. _____ Date of Birth _____ Sex: M / F
(Last) (First) (initial)

DENTAL CONCERNS & PREFERENCES

What are your primary dental concerns? _____

_____

Importance of Each: circle on a scale of 1 (lowest) to 5 (highest)

Preventative Care 1 2 3 4 5
Overall Wellness 1 2 3 4 5
Extraordinary Service 1 2 3 4 5
Freedom from Pain 1 2 3 4 5
Cost & Affordability 1 2 3 4 5
Appearance of Smile 1 2 3 4 5
Extraordinary Quality of Treament 1 2 3 4 5
Avoiding Dentures / Removable Teeth 1 2 3 4 5

When discussing treatment I prefer (circle): BIG PICTURE or DETAIL BY DETAIL

Do you feel nervous about dental treatment? YES or NO

Have you had a bad dental experience? YES or NO If yes describe _____

_____

Is there something we can do to make you more comfortable? _____

DENTAL HISTORY

When was your last dental visit? _____
Reason for visit? _____
Name of previous dentist _____
Location (City / State) _____
Date of last exam _____
Date of last xray(s) _____
Date of most recent treatment _____

	Present	Past	None
Sensitive Teeth	☐	☐	☐
Bleeding Gums	☐	☐	☐
Bad Breath	☐	☐	☐
Loose Teeth	☐	☐	☐
Clenching / Grinding	☐	☐	☐
Orthodontic Treatment	☐	☐	☐
Perio Treatment	☐	☐	☐
Smoking / Tobacco	☐	☐	☐
Oral Surgery / Extractions	☐	☐	☐
Dental Implants	☐	☐	☐
Cold Sores	☐	☐	☐
Freq. Sugary Drinks/ Juices	☐	☐	☐

AESTHETICS

Smile aesthetics expectations: LOW / MEDIUM / HIGH

Are you happy with your smile? YES or NO

What would you change? _____

TMJ

Have you ever been diagnosed with a problem with either jaw joint? YES or NO

Does your jaw click, pop, or make noise when you open or close? YES or NO

Has your jaw ever locked open or closed? YES or NO

Do you get headaches? If so how often or when? YES or NO If yes _____

Do you clench or grind your teeth or been told that you do? YES or NO

Do you have a history of trauma to your chin or jaw? YES or NO

Have you worn a nightguard? YES or NO

SLEEP

Have you ever been diagnosed with sleep apnea? YES or NO

Do you wear a CPAP or dental appliance? YES or NO If yes what _____

Do you snore? YES or NO

RELEASE & PHOTO IMAGE PUBLICATION CONSENT VERIFICATION AGREEMENT

Valley Advanced Orthodontics is dedicated to improving standards of care through the delivery of extraordinary treatment, research and sharing of expertise. This photo release allows us to lecture, teach, publish and learn in the pursuit of dental excellence. If you have any questions or concerns with this agreement please feel free to discuss them with a treatment coordinator or your dentist prior to signing.

_____

Patient Name

This AGREEMENT is for the purpose of identifying any express or implied agreement, including, but not limited to, permission, consent, release, and/or authorization between DENTIST/PRACTICE and PATIENT in connection with the medical services PATIENT received from DENTIST / PRACTICE.

DENTIST / PRACTICE and PATIENT warrant and represent that PATIENT has given CONSENT and FULL AUTHORIZATION that any photographs and/or images of PATIENT, under the following conditions.

1. The photographs and/or images & videos will be taken by DENTIST/PRACTICE or by a photographer and/or skilled operator approved by DENTIST/PRACTICE.

2. The photographs and/or images may be used for:

   a. Identification purposes, medical records, and if in the judgment of DENTIST/PRACTICE, medical research, education or science will be benefited by their use. Such photographs and/or images and information relating to PATIENT may be published or republished, either separately or in connection with each other, in but not limited to, professional journals, medical books, medical based Internet websites, or any other purpose which DENTIST / PRACTICE may deem proper in the interest or, but not limited to, medical education, knowledge, or research; and or

   b. PATIENT further authorizes that the photographs and/or images may be used by DENTIST/PRACTICE or by an entity approved by DENTIST/PRACTICE in promotional printed, computer website and / or video material.

   _____ OK to use full face images for promotional & video material
   _____ Please refrain from using full face images in promotional material

3. At no time will PATIENT'S name, address, or any other alpha/numeric PATIENT identifiable information be used in connection with the publication of the photographs and / or images of PATIENT. PATIENT acknowledges the possibility that his/her identity may become known as a result of the publication and use of the photographs and / or images described in paragraph 2; above.

4. The photographs and / or images & video may be modified and / or retouched in any way in DENTIST'S / PRACTICE discretion.

By signing below, PATIENT certifies that he / she has read and understood each and every section of this Agreement, and agrees to be bound by its terms.

_____ _____

_____ _____

WITNESS DATE

VALLEY ADVANCED
ORTHODONTICS

INSURANCE AGREEMENT

Dear Patient,

We have prepared this letter to help you better understand the complexities of dental insurance. We realize how confusing it can be. To begin, we would like to highlight a misconception--dental insurance is not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payment. However, at Valley Advanced Orthodontics we are committed to working with you and your insurance company in order to provide the best and most affordable treatment.

All levels of payment by insurance companies, including allowed fees and UCR's (usual and customary rates), are governed by the premiums they are paid. They do not reflect actual dental costs. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on the restraints of your insurance contract.

It should be understood that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility. All estimated co-pays for treatment performed at our office is due at the time of service.

We hope this information has been helpful. Please take the time to review your insurance contract throughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

_____

Patient Name (Printed) Date

_____

Patient Signature

VALLEY ADVANCED ORTHODONTICS

Cancelation and Financial Standard

Valley Advanced Orthodontics provides our patients with the best possible care and service. By signing this Cancelation and Financial Standard, you are acknowledging and agreeing to follow our practice Standards as outlined below:

FINANCIAL OBLIGATIONS: we ask that you pay your deductible and/or any estimated out of pocket expenses at the time of service by using Care Credit, cash, check, or credit card (to include HSA or FSA). If you do not have dental insurance, please ask us about our Verber Dental Plan (VDP).

MONTHLY STATEMENTS: if you have a balance on your account after all claims have processed, we will send you a monthly statement. Payment is expected upon receipt. If you miss a payment, or cannot make a payment, then we ask that you contact the office where services were rendered.

PAST DUE ACCOUNT: if your account becomes 90-days past due, we will take necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all collection fees which are incurred. This could also result in dismissal of your care from our practice.

CHARGES TO ACCOUNT: we retain the right to cancel your privilege to make charges against your account at any time and could require prepayment for future services.

MISSED APPOINTMENTS: kindly provide 1 business days' notice if you are unable to keep your appointment. Failure to do so will result in a $50 charge to your account and a corresponding letter. In limited circumstances, we will consider waiving this missed appointment fee. Arriving for your appointment 10 (or more) minutes late may result in your being asked to reschedule.

DISMISSAL: a letter of dismissal will be sent to the patient after their third missed appointments or appointments canceled within 24-hours. We will continue to see the patient on an emergency basis for up to 30-days after their last missed appointment.

TRANSFER OF RECORDS: if you request to have your records transferred to another facility either by mail or hand carried by you, there could be a charge of up to $25. There is no fee to have records transferred to another office electronically. Please allow up to 7 business days to transfer your complete records upon your request.

By signing this form, you acknowledge that you have read all the terms and conditions contained herein and the agreement will be in full effect.

Patient Name: _____ Date: _____

Signature: _____

Responsible Party (if not the patient): _____

HIPAA
Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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 RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. Ask for an electronic or paper copy of your health record
- You can ask to see or get an electronic or paper copy of your health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

2. Ask us to correct your health record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

3. Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

4. Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

5. Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

6. Get a copy of this Privacy Notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

7. Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

8. File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information at the end of this document.
- You can file a complaint with the U.S. Dept. of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201; calling 800-368-1019 (TDD: 1-800-537-7697); or visiting: hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

1. In the situations below, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

2. In the situations below, we never share your information unless you give us written permission:
- Marketing purposes • Sale of your information • Most sharing of psychotherapy notes

3. In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways:

1. Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

2. Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

3. Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

1. We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

2. Do research

We can use or share your information for health research.

3. Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

4. We can share health information about you with organ procurement organizations.

5. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

6. Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

7. We can share health information about you in response to a subpoena, or in response to a court or administrative order.

OUR RESPONSIBILITIES

1. We are required by law to maintain the privacy and security of your protected health information.
2. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
3. We must follow the duties and privacy practices described in this Notice and give you a copy of it.
4. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

Complaints: If you believe your privacy rights have been violated contact our Privacy Officer at:

inUnison Consulting, LLC • 292 Main Street, Suite 290, Harleysville, PA 19438
877-222-2027 • www.inUnisonConsulting.com

VALLEY ADVANCED ORTHODONTICS

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I had the opportunity to review and/or obtain a copy of this office's Notice of Privacy Practices.

Print Name:_____ Date of Birth: _____

Signature: _____

Relationship to patient (if signed by personal representative of patient):_____

Date:_____

☐ ***Please check the box if we are able to leave a message with medical & financial information on phone numbers***

Please list individuals names that we are allowed to release financial and medical information to:

1_____ 2_____

** You May Refuse to Sign This Acknowledgment**

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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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