Dr. Sean M. Rooney
Children & Adult Orthodontics

Dear New Patient:

Welcome to our office! We are looking forward to meeting you.

Your complimentary appointment is scheduled for approximately 30 minutes with Dr. Rooney. We will have a chance to get acquainted and examine Sean's teeth to determine if orthodontic treatment is appropriate at this time. Many of your questions will be answered at this appointment.

Enclosed you will find information about Dr. Rooney, an orthodontic treatment booklet that we hope you will find helpful, a medical/dental history form and a patient registration form. Please complete these forms and bring them with you to your appointment.

Also provided, as required by federal law, is a copy of our Notice of Privacy Practices, an Acknowledgement of Receipt of Privacy Practices and Consent for Use and Disclosure of Health Information. Please sign and return them at your visit, as well.

For your convenience, we have included directions to our office. If you have any questions prior to your appointment, please call.

Sincerely,

Casey Hechler
Scheduling Coordinator
/CAH

Patient Registration

Dr. Sean M. Rooney
Children & Adult Orthodontics

54 Miller Road
Mahopac, NY 10541
Phone: 845-621-1222
Fax: 845-621-5479
E-Mail: Braces4@Rooneyortho.com

Patient Information: Please correct if needed. Thank you!

Patient's Name: _____ Nick Name:_____ Sex: _____ D.O.B. _____

Address: _____

Home Phone: _____ E-mail (for Appointments) _____

Would you prefer appointments confirmed by phone or email?(if phone which #)_____

Who may we thank for recommending us?_____

Name of Dentist:_____ Date of Last Visit:_____

Name of Physician:_____

School if Student:_____ Grade:_____

Patient's Hobbies(sports, music, activities, etc.)_____

Parental Information: Please complete if patient is a minor.

Father's Name _____

Address if different from patient's _____

_____

Home Phone if different from patient's_____

Cell Phone:_____
Work Phone:_____
Fax:_____

Occupation/Employer _____

Stepfather/Guardian - Please circle if applied

Mother's Name _____

Address if different from patient's _____

_____

Home Phone if different from patient's_____

Cell Phone:_____
Work Phone:_____
Fax:_____

Occupation/Employer _____

Stepmother/Guardian - Please circle if applied

If divorced who is the custodial parent _____
May patient info be released to the noncustodial parent: Yes No (Please Circle)

Additional Children and their ages: _____

Thank you for taking
the time to complete.

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Insurance Information

Primary Insurance

Insured's Name _____

Insured's Soc Sec No._____

ID No._____

Insured's Employer _____

Insurance Co. Name_____

Insurance Co. Phone Number_____

Insurance Co. Address_____

_____

Insured's Date of Birth _____

Secondary Insurance

Insured's Name_____

Insured's Soc Sec No._____

ID No._____

Insured's Employer _____

Insurance Co. Name_____

Insurance Co. Phone Number_____

Insurance Co. Address_____

_____

Insured's Date of Birth_____

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Patient: Age:

Medical History

Please check if the patient has or has had:

[Y]	[N]	
[ ]	[ ]	Joint Swelling
[ ]	[ ]	Bone Disorders
[ ]	[ ]	Heart Trouble
[ ]	[ ]	Mitral Valve Prolapse
[ ]	[ ]	Rheumatic Trouble
[ ]	[ ]	Thyroid Problems
[ ]	[ ]	Diabetes
[ ]	[ ]	Emotional Problems
[ ]	[ ]	Brain Injury
[ ]	[ ]	Kidney or Liver involvement
[ ]	[ ]	Joint Prosthesis

[Y]	[N]	
[ ]	[ ]	Tuberculosis
[ ]	[ ]	Anemia
[ ]	[ ]	Epilepsy (Convulsions)
[ ]	[ ]	Prolonged Bleeding
[ ]	[ ]	Faintness/Dizziness
[ ]	[ ]	Tonsils Removed
[ ]	[ ]	Adenoids Removed
[ ]	[ ]	Sore Throats
[ ]	[ ]	Tonsillitis
[ ]	[ ]	Earaches
[ ]	[ ]	Arthritis

On items checked "Yes" please provide us with a more detailed description:

Dental History

Please check Yes or No:

[Y]	[N]	
[ ]	[ ]	Any injuries to face, mouth, teeth? (circle)
[ ]	[ ]	Thumb, finger, lip sucking? (circle)
[ ]	[ ]	More than average amount of decay?
[ ]	[ ]	Any missing permanent teeth?
[ ]	[ ]	Any extra permanent teeth?
[ ]	[ ]	Any teeth removed by extraction?
[ ]	[ ]	Any difficulty in swallowing or chewing?
[ ]	[ ]	Any pain or clicking on opening mouth?
[ ]	[ ]	Is patient adopted? At what age?_____
[ ]	[ ]	Does patient visit the dentist regularly? Date of last visit to dentist _____
[ ]	[ ]	Has an orthodontist been consulted previously ?

Reason:

Approximately how much has the patient grown in the last year?

Have you or any member of your family or close relative had:
Rheumatoid Arthritis [ ] Yes [ ] No Lupus [ ]Yes [ ]No

What would you like to have orthodontic treatment accomplish?

List any serious illnesses:

List any allergies (such as metals, latex, nickel, aspirin, codeine, ibuprofen (Motrin, Advil), local anestetics etc):

List Drugs or medications now being taken (such as bisphosphonates ie. Actonel, Aredia, Boniva, Didronel, Fosamax, Reclast, Skelid, Zometa):

Is patient presently under physician's care?
Reason:

Name of Primary Physician: Name of other Physician(s):

Patients Attitude toward orthodontic treatment:
(circle) Very Motivated Will cooperate if needed Not motivated

Adolescent Females: Has menstruation begun? [ ] Yes [ ] No
If Yes approximately how long ago?

To the best of my knowledge, the above information is complete and correct. If there are any changes in health or medication, I will inform Dr. Sean M. Rooney.

Signature of Patient or Parent or Guardian if Patient is a Minor

Date

Notice of Privacy Practices

This notice describes how health information about the patient may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. You must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 8, 2007, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about your treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or of the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions, You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so (You may make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we can , at our discretion, charge you $.25 for each printed page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. Additional laboratory fees would apply to copy study models and x-rays. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before January 8, 2007. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will be handled under the alternative means or locations you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice by e-mail, you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jennifer Rooney **Telephone:** (845) 621- 1222

Address: 54 Miller Road, Mahopac NY, 10541 **Fax:** (845) 621 -5479

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
Patient or adult guardian
Privacy Practices.

_____
Name of Patient

_____
Signature of Patient or Adult Guardian

_____
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

____ A communication barrier prohibited obtaining acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____Other (Please specify)

_____

_____

_____

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Consent for Use and Disclosure of Health Information

Section A: Consent for Patient:

Name:

Section B: To the Patient (or Adult Guardian)–Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the Changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time, by contacting:

Contact Person: Jennifer Rooney **Telephone:** (845) 621-1222
Address: 54 Miller Road, Mahopac, NY 10541 **Fax:** (845) 621-5479

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I Give My Consent

I,_____, have had full opportunity to read and consider the contents of this
Patient or adult guardian
Consent form and your Notice of Privacy Practices, I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____
Patient or adult guardian

OR

Revocation of Consent

I, _____, revoke my Consent for your use and disclosure of my protected
Patient or adult guardian
health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I revoke my Consent.

Signature_____ Date_____
Patient or adult guardian

You are entitled to a copy of this consent after you sign it. One will be held in your chart.