DEL R. BONI, D.M.D.
SPECIALIST IN ORTHODONTICS

Date_____

Patient Information (CONFIDENTIAL)

Name _____Birthdate _____Phone # _____
Address _____City_____State____ Zip_____
Whom May We Thank for Referring You?_____
Person to Contact in Case of Emergency_____Phone # _____

Parent Information (If Patient is a Minor)

Mother's Name _____Birthdate_____
Address_____City_____State____ Zip_____
Phone # (home/cell)_____
Name of Employer_____Work Phone _____

Father's Name_____Birthdate_____
Address_____City_____State____ Zip_____
Phone # (home/cell)_____
Name of Employer_____Work Phone _____

Responsible Party

Person(s) Responsible for this Account _____ Phone _____
Address_____Relationship to Patient _____
Name of Employer_____Work Phone _____

Insurance Information

Primary Insurance

Name of Policy Holder_____
Relationship to Patient _____
Policy Holders Birthdate_____
Social Security #_____Group # _____
Insurance Company _____

Secondary Insurance

Name of Policy Holder_____
Relationship to Patient _____
Policy Holders Birthdate_____
Social Security #_____Group # _____
Insurance Company _____

Medical History

YES	NO	Birth Defects or hereditary problems?	YES	NO	Stomach ulcer or hyperacidity?
YES	NO	Bone fractures, any major accidents?	YES	NO	Polio, mononucleosis, tuberculosis, pneumonia?
YES	NO	Rheumatoid or arthritic conditions?	YES	NO	Problems of the immune system?
YES	NO	Endocrine or thyroid problems?	YES	NO	Hepatitis, jaundice or liver problem?
YES	NO	Kidney problems?	YES	NO	AIDS or HIV Positive?
YES	NO	Diabetes?	YES	NO	Sexually transmitted disease?
YES	NO	Cancer or been treated for a tumor?	YES	NO	Fainting spells, seizures, epilepsy?

Over Please

YES NO Mental health or behavioral problems?
YES NO Vision, hearing, tasting or speech difficulties?
YES NO Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
YES NO High or low blood pressure?
YES NO Chest pain, shortness of breath or swelling ankles?
YES NO Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
YES NO Artificial Prosthesis?
YES NO Frequent headaches, colds or sore throats?
YES NO Any history of speech problems?
YES NO Eye, ear, nose, throat condition?
YES NO Hayfever, asthma, sinus trouble, hives?
YES NO Tonsil or adenoid conditions?
YES NO Allergies or drug reactions?
YES NO Are you taking any medication, nutrient supplements or non prescription medicine? Please list:

_____

YES NO Do you currently have or ever had a substance abuse problem?
YES NO Operations?
YES NO Hospitalized? For_____
YES NO Other physical problems or symptoms?
YES NO Being treated by another health care professional? For _____
YES NO Are you in good health? Date of most recent physical exam? _____

Female Patient

YES NO Are you pregnant?
YES NO Are you taking birth control pills?

Dental History

YES NO Chipped or otherwise injured permanent teeth?
YES NO Teeth sensitive to hot or cold: teeth throb or ache?
YES NO Jaw fractures, cysts, mouth infections?
YES NO Dead Teeth" Root canals treated?
YES NO Bleeding gums, bad taste, mouth odor?
YES NO Periodontal "Gum Problems"?
YES NO Food impaction between teeth?
YES NO Gum Boils", frequent canker sores, cold sores?
YES NO Thumb, finger, pacifier habit? Until_____
YES NO Abnormal swallowing habit (tongue thrusting)?
YES NO Mouth breathing habit, snoring, difficulty in breathing?
YES NO Tooth grinding, jaw clenching, clicking, locking?
YES NO Do you experience any pain or soreness in the muscles of your face, or around the ears?
YES NO Any pain in jaw or ringing in the ears?
YES NO Have you ever been treated for TMJ problems (your jaw joint and facial muscle pain?)
YES NO Difficulty encountered in chewing or jaw opening?
YES NO History of supernumery (extra) or congenitally missing teeth?
YES NO Have any permanent teeth been removed?
YES NO Aware of loose, broken or missing restorations (fillings)?
YES NO Any teeth irritating cheek, lip, tongue, palate?
YES NO Have you ever had Orthodontic treatment or worn a "retainer" or "bite plate"?
YES NO Have you recently been under another dentist's care? Specialist_____
YES NO Have you ever had Periodontal (gum) treatment?
YES NO Concerned about spaced, crooked, protruding teeth?
YES NO Aware or concerned about ubder or over developed jaw?
YES NO Any relative with similar tooth or jaw relationships?
YES NO Any wisdom tooth problems?
YES NO Have you had any serious trouble associated with any previous dental treatment?

What is your primary concern - Why are you here?_____

_____

_____

_____

Date of most recent dental examination?_____

How often do you brush_____ floss_____

Realizing that succesful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that i have made in the completion of this form.

If there are any changes later to this history record or medical/dental status, I will so inform this practice.

_____

Signature of patient or parent if minor ***Date***

_____

Signature of Doctor ***Date***

Medical History Update/Changes

Office Use Only

Date: Comments: Doctor's Signature:

_____

_____

_____

_____

DEL R. BONI, D.M.D.
SPECIALIST IN ORTHODONTICS

{NAME OF PRACTICE}

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU 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. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, 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 the 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 you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and 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 this 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 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 institution or law enforcement official 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 messages, 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 must 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 a 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 will charge you $0._____ for each page, $ TBD per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 April 14, 2003. 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.

Restriction: 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 location, and provide satisfactory explanation how payments will be handled under the alternative means or location 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 on our Web site or by electronic mail (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 with the U.S. Department of Health and Human Services 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: ANNETTE

Telephone: 724 695.3545

Address: 180 IMPERIAL PLAZA DR, STE 100
IMPERIAL, PA 15126

AUTHORIZATION FOR SIGNATURE ON FILE

I,_____hereby authorize the office, of Dr. Del Boni to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment. I hereby authorize payment of orthodontic benefits otherwise payable to me directly to the office of Dr. Del Boni. A photocopy of this document may act as an original.

MINOR / CHILD CONSENT

I, being the parent or guardian of_____do hereby request and authorize the orthodontic staff to perform necessary orthodontic services for my child, but not limited to x-rays and administration or anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also do hereby authorize the following named adult(s) authority to make orthodontic care decisions and receive information for the above-mentioned minor in my absence.

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____have been given an opportunity to review this office's notice of privacy practices on this date:_____
I,_____refuse to sign this acknowledgement.
Date: _____

_____Communication barriers prohibited obtaining acknowledgement.
_____Emergency situation prevented us from obtaining acknowledgement.
_____other:_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I,_____, understand by signing this form, I will consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. Your office will continue to use my health information in some of these ways: by calling me by my first and last name from your waiting room, by posting patient pictures, by mailing me reminder appointment cards with reason for visit, by reminding patients needing a pre-medication on reminder cards or confirmation calls, by calling to confirm appointments and internal audits of patients' charts for practice evaluation purposes. You have the right to request alternative means of delivery.

Signature:_____

You can contact me at ____home___work____email_____other to confirm my appointments.
(please check)

_____home_____e-mail

_____office_____other