Matthew Sanders, DDS, MS
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916.512.3600 • 7300 Laguna Blvd, Suite 3; Elk Grove, CA 95758 • fax 916.635.1475
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PATIENT REGISTRATION & INFORMATION

Date: _____

Last Name_____ First_____ Middle_____ Sex_____

Birthdate_____ Age____ Phone No._____ Patient's Email_____
Home / Mobile / Work

Address – Street_____

City_____ State_____ Zip Code_____

Name of Dentist / Dental Office_____

Address_____ Phone No._____

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

Adult Patient: Single_____Married_____Widowed_____Separated_____Divorced_____

Occupation_____Business Phone No._____

Minor Patient: Birth Weight_____ Present Weight_____ Height_____

School_____ Grade Level_____

Favorite Sports and Hobbies_____

Musical Instruments Played_____

Number of Brothers and Sisters_____ Ages_____

Other Family Members Treated_____

Responsible Party Information, *please list anyone who will be bringing the minor patient to appointments, responsible for financial matters, and responsible for treatment matters*

Full Name_____Sex_____ Relationship to Patient_____

Birthdate_____ Phone Number _____ Email_____

Full Name_____Sex_____ Relationship to Patient_____

Birthdate_____ Phone Number _____ Email_____

Full Name_____Sex_____ Relationship to Patient_____

Birthdate_____ Phone Number _____ Email_____

DENTAL (ORTHODONTIC) Insurance Coverage Yes_____ No_____

Insurance Co. Name_____ Policy/Group No._____

Subscriber's Name_____ **DOB:** _____ Relationship to Patient_____

Subscriber's SSN # _____ Subscriber's Insurance ID# _____

*** The Social Security Number is **required** if a member/subscriber ID number is not known.*

Subscriber's Address (if different than patient's address) _____

City_____ State_____ Zip Code_____

*The following information is **required** if the insurance plan is provided by an employer*

Company Name_____ Group No. _____

Company Phone No._____ Address _____

City_____ State_____ Zip Code_____

In Case We Cannot Reach You:

Name:_____ Phone No._____ Relationship to Patient_____

Please continue on the back side...

For the following questions circle **yes**, **no**, or **don't know/understand (dk/u)**. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Medical History

Minors Only

yes no dk/u Started teething very early or very late?
yes no dk/u Does patient have trouble following directions?
yes no dk/u Does patient have learning disabilities or need extra help with instructions?
yes no dk/u Are you taking birth control pills?
yes no dk/u Is patient sensitive, self-conscious?

Adults and Minors

yes no dk/u Birth defects of hereditary problems?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Kidney problems?
yes no dk/u Cancer or been treated for a tumor?
yes no dk/u Problems of the immune system?
yes no dk/u Vision, hearing, tasting, or speech difficulties?
yes no dk/u Fainting spells, seizures, epilepsy, or neurologic problem?
yes no dk/u Do you have a poor and unhealthy diet?
yes no dk/u Sexually transmitted diseases? Please list:_____
yes no dk/u Chest pain, shortness of breath, or swelling ankles?
yes no dk/u Hayfever, asthma, sinus trouble, hives?
yes no dk/u Currently have or ever had a substance abuse problem?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Diabetes?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u High or low blood pressure?
yes no dk/u Polio, mono, tuberculosis, pneumonia?
yes no dk/u Tires easily?
yes no dk/u AIDS or HIV positive?
yes no dk/u Eye, ear, nose, throat, tonsil, adenoid conditions?
yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u Are you pregnant or expecting to become pregnant?
yes no dk/u Are there any mental health problems? Please list: _____
yes no dk/u Excessive bleeding, black and blue tendency, anemia, or bleeding disorder?
yes no dk/u Cardiovascular problem, heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, or rheumatic heart?
yes no dk/u Allergies or drug reactions? Please list: _____
yes no dk/u Are you taking medication, supplements, or non-prescription medicine? Please list:_____
yes no dk/u Operations/Surgical procedures/Hospitalizations for: _____
yes no dk/u Other physical problems or symptoms?_____
yes no dk/u Is the patient seeing any other health care professional? For_____
yes no dk/u Is the patient currently taking or has previously taken a bisphosphonate medication?

Dental History

Minors Only

yes no dk/u Does patient have trouble following directions?
yes no dk/u Removal of (baby) teeth that were not loose?
Onset of puberty (approximate age)_____

Adults and Minors

yes no dk/u Prior orthodontic treatment? When?_____
yes no dk/u Permanent or "extra" (supernumerary) teeth removed?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u "Dead Teeth", root canals treated?
yes no dk/u Thumb, finger, sucking habit? Until_____
yes no dk/u Abnormal swallowing habit (tongue thrusting)?
yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?
yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u Concerned about spaced, crooked, protruding teeth?
yes no dk/u Has patient ever had periodontal (gum) treatment?
yes no dk/u Jaw fractures, cysts, mouth infections?
yes no dk/u Bleeding gums, bad taste, mouth odor?
yes no dk/u Periodontal disease, "Gum Problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u History of speech problems?
yes no dk/u Difficulty chewing or opening jaw?
yes no dk/u Any pain in jaw or ringing in the ears?
yes no dk/u Any relative with similar tooth or jaw problems?
yes no dk/u Loose, broken, or missing restorations (fillings)?
yes no dk/u Any wisdom tooth problems?
yes no dk/u Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain?)
yes no dk/u Does the patient experience any pain or soreness in the muscles of the face, or around the ears?
yes no dk/u Has patient had any serious trouble associated with any previous dental treatment?
yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

Date of most recent dental examination_____ How often does patient brush?_____ Floss?_____

What is the patient's (or guardian's) primary concern? Why are you here today?_____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her 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/guardian **Printed Name** **Date**

Signature of Doctor **Date**

MEDICAL & DENTAL HISTORY UPDATE – Should be completed at least once a year. Are there any changes to your medical and dental history that we should be aware of? Please write "none" or explain:_____

Signature of patient/guardian **Printed Name** **Date**

Signature of Doctor **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIPAA – Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (also known as HIPAA) is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practices is to explain how Sunrise Orthodontics may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Sunrise Orthodontics has always taken great care to protect the integrity and confidentiality of your health care information, we are required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the Notice.

Our Notice of Privacy Practices is available for you to view at our office, and can also be obtained via e-mail or fax. Signing below indicates that you have had the opportunity to review the Notice of Privacy Practices.

I certify that I have had the opportunity to review the Notice of Privacy Practices of Sunrise Orthodontics, Matthew Sanders, DDS, Inc.

Patient _____

Signature of Responsible Party _____

Printed Name of Responsible Party _____

Relationship to Patient _____

Date _____

E-mail: sunriseorthodontics@gmail.com

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Telephone: 916.635.5717

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Telephone: 707.316.8212

Address: 3171 Washington St.; Placerville, CA 95667
Telephone: 530.622.6546

HIPAA 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.

PURPOSE OF THIS NOTICE

Healthcare offices must provide this notice to each patient who begins treatment after April 14, 2003. We must make a good faith effort to obtain written acknowledgement of receipt of this notice from each patient. We must have this notice available at the office for patients to request to take with them. We must post the notice in our office in a clear and prominent location to be reviewed by the patient. Sunrise Orthodontics is committed to maintaining your health information in a private and confidential manner. This Notice will give you information regarding our privacy practices. This notice applies to all of your health information maintained in our office and includes any information that we receive from other health care providers or facilities. The Notice describes the ways in which

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect November 1, 2010, 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 provide the new Notice at our practice location, and we will distribute it 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.

YOUR AUTHORIZATION: In addition to our use of your health information for the following purposes, 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.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you without authorization for the following purposes:

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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, text messages, electronic mail, postcards, or letters).

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. You may also request access by sending us a letter to the address at the end of this Notice. We may charge you a reasonable cost-based fee for the cost of supplies and labor of copying. 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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: Management Team - Rancho Cordova Privacy Officer: Chelsea Suafoa,
Elk Grove Privacy Officer: Julie Zhur, Placerville/Dixon Privacy Officer: Zaira Miranda

Telephone: 916.635.5717 **E-mail**: sunriseorthodontics@gmail.com

Address: 2483 Sunrise Blvd.; Rancho Cordova, CA 95670