JOHN R.
VALANT
DDS · MSD
ORTHODONTICS & DENTOFACIAL ORTHOPEDICS

Patient Information

Patient's Name_____Date___/___/____
Address_____City_____State___Zip_____
Cell Phone ____-____-_____Birthdate____/____/____Patient age___yr___mo
SS#____-____-____How did you hear about our office?_____
Email _____

Responsible Party Information

Responsible Party's Name_____Spouse's Name_____
Mailing address_____City_____St._____
How Long at this Address?_____Home Ph.___-____Work Ph.___-____
Previous address?(if less than 3yrs)_____City_____St._____
SS#___-___-____ Birthdate___/___/___ Relationship to Patient_____
Employer_____No. yrs_____
Employer address_____ Occupation_____
Other Parent's Name(if different than spouse)_____
Mailing address_____City_____St._____
Relationship to Patient_____Home Ph.____-____Work Ph___-____
SS#___-___-____ Birthdate___/___/___ Employer_____No. yrs_____
Employer address_____ Occupation_____

Insurance Information

Insured's name_____Birthdate___/___/___Insured's SS#____-___-____
Insurance Company_____Group No._____ Local No. _____
Insurance Co. Address_____
Insurance Co. Phone No. ___-___-____ Insured's Employer_____
Do you have dual coverage? Yes ☐ No ☐ If Yes:
Insured's Name_____Birthdate___/___/___ Insured's SS#___-___-____
Insurance Co. _____Group No. _____Local No._____
Insurance Co. Address_____
Insured's Employer_____

Emergency Information

Name of nearest relative not living with you_____
Complete Address_____
Daytime Phone _____-_____

I understand that where appropriate, credit bureau reports may be obtained
Signature (Parent's signature if minor)_____Date ___/___/___

241 EAST FM 1382, #322 • CEDAR HILL, TEXAS 75104
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DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Member American Association of Orthodontists

Medical Information

Please indicate YES if you currently have or have ever had any of the following medical conditions

Heart Disease?	Yes ☐ No ☐	Mononucleosis?	Yes ☐ No ☐	_____
Respiratory Disease?	Yes ☐ No ☐	Hepatitis?	Yes ☐ No ☐	_____
Blood Disease?	Yes ☐ No ☐	Polio?	Yes ☐ No ☐	_____
Liver Disease?	Yes ☐ No ☐	Diabetes?	Yes ☐ No ☐	_____
Thyroid Disease?	Yes ☐ No ☐	Anemia?	Yes ☐ No ☐	_____
Kidney Disease?	Yes ☐ No ☐	Hemophilia?	Yes ☐ No ☐	_____
Venereal Disease?	Yes ☐ No ☐	Emphysema?	Yes ☐ No ☐	_____
Intestinal Disease?	Yes ☐ No ☐	Epilepsy?	Yes ☐ No ☐	_____
Bone Disease?	Yes ☐ No ☐	Nervous/Emotional Problems?	Yes ☐ No ☐	_____
Endocrine Problems?	Yes ☐ No ☐	High or Low Blood Pressure?	Yes ☐ No ☐	_____
HIV Positive?	Yes ☐ No ☐	Problems with Wound Healing?	Yes ☐ No ☐	_____
Blood Transfusion?	Yes ☐ No ☐	Rheumatic/Scarlet Fever?	Yes ☐ No ☐	_____
Tumors or Cancer?	Yes ☐ No ☐	Rheumatism or Arthritis	Yes ☐ No ☐	_____
Asthma or Hay Fever?	Yes ☐ No ☐	Is Patient Under medical Care?	Yes ☐ No ☐	_____
Tuberculosis?	Yes ☐ No ☐	History of Fainting or Dizziness?	Yes ☐ No ☐	_____
Any Broken Bones?	Yes ☐ No ☐	Does the Patient have a drug addiction?	Yes ☐ No ☐	_____
Prolonged Bleeding?	Yes ☐ No ☐	Is the Patient Pregnant at this time?	Yes ☐ No ☐	_____
Yellow Jaundice?	Yes ☐ No ☐	Does the Patient Smoke?	Yes ☐ No ☐	_____
Radiation Therapy?	Yes ☐ No ☐	Is the Patient in Good Health?	Yes ☐ No ☐	_____
Chemical Therapy?	Yes ☐ No ☐	Has the Patient ever had Fever Blisters?	Yes ☐ No ☐	_____

If female, Has Menstruation begun? Yes ☐ No ☐
Is the Patient allergic to anything? Yes ☐ No ☐
Please list all allergies_____
Is the Patient currently taking any medications? Yes ☐ No ☐
Please list all medications_____
Are you aware of any other disease, condition, or problem not listed above that we should know about? Yes ☐ No ☐
Please List_____

Dental History

Has the Patient Seen a General Dentist in the Last Year?	Yes ☐ No ☐	_____
Any Pain, Clicking or Discomfort In or Near the Ears?	Yes ☐ No ☐	_____
Has the Mouth, Face or teeth been Injured by a Fall or Accident?	Yes ☐ No ☐	_____
Have You been Informed of Missing or Extra Permanent Teeth?	Yes ☐ No ☐	_____
Are You Aware of Any "Gum" Problems?	Yes ☐ No ☐	_____
Has a Physician or Dentist Advised Antibiotics Before a Dental Exam?	Yes ☐ No ☐	_____
Have the Patient's Tonsils or Adenoids Been Removed?	Yes ☐ No ☐	_____
Do You Feel the Patient Can Benefit From Orthodontic Treatment?	Yes ☐ No ☐	_____
Is the Patient Happy with Their "Smile"?	Yes ☐ No ☐	_____
Does the Patient Want to Improve Their "Smile" and "Bite"?	Yes ☐ No ☐	_____
Would the Patient Mind Wearing "Braces"?	Yes ☐ No ☐	_____

Does the Patient Have or Ever Had Any of the Following Habits?

Cheek, Tongue, or Lip Chewing?	Yes ☐ No ☐	Clenching Teeth?	Yes ☐ No ☐
Finger Nail Biting?	Yes ☐ No ☐	Tongue Thrusting?	Yes ☐ No ☐
Thumb Sucking?	Yes ☐ No ☐	Grinding teeth?	Yes ☐ No ☐
Mouth Breathing?	Yes ☐ No ☐	Speech Problems?	Yes ☐ No ☐

Has the Patient been examined by an orthodontist before? If Yes, When_____
Have Other Members of the Family had Orthodontic Treatment? If Yes, Were you Happy With the Results? Yes ☐ No ☐
If No, Why?_____
In Your Own Words, What is the Orthodontic Problem?_____

I understand the information given is correct and will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in the patient's medical status.

_____ ___/___/___ _____
Patient Signature Date Parent Signature

Updates(date&initial)_____

John R Valant DDS, MSD

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.

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. This Notice takes effect October 1, 2002, 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, within application of the law. You may request a copy of our Notice at any time.

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 improvement activities, conducting education programs, scientific meetings, accreditation, certification, licensing or credentialing activities.

Authorization: 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 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.

Persons Involved In Care: We may disclose health information to persons involved with your care based on 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 in allowing a person to pick up medications, 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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to health information to officials for national security activities.

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 must make a request in writing to obtain access to your health information). We will charge you a reasonable cost-based fee for the expenses involved, such as copies and staff time.

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).

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.

QUESTIONS AND COMPLAINTS:

Please contact us for additional clarification or questions concerning this policy.

If you feel that we should manage your privacy in any other manner, please contact us.

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.

John R Valant, DDS, MSD
241 East F.M. 1382, Suite 322
Cedar Hill, Texas 75104

Welcome to our office. We are happy you have chosen us for your orthodontic care. As a courtesy to you, we have tried to answer some questions you may have about finances and insurance.

1. We accept cash, checks, some credit cards and electronic transfer for payments.
2. We will accept payments from your primary insurance carrier. Any additional payments from secondary policies will be your responsibility. After verification of your benefits, you will be asked to pay the estimated portion not covered by your primary carrier. You are therefore responsible for any unpaid balances.
3. All balances must be paid prior to removal of braces.
4. Extended treatment time can result in additional fees.
5. Dr. Valant will do a complete orthodontic exam. He will recommend treatment that you may need to optimize your dental health. You will always be informed of any costs involved prior to treatment.

Please read the following and sign for our records;

Release of information, insurance authorization, and Notice of Privacy:

I consent to the use and disclosure of my protected health information necessary to carry out treatment, payment activities and healthcare operations.

Date _____ Signature _____

I authorize the payment of medical and /or dental benefits to Dr. Valant for services rendered. I understand I am responsible for payment in full for services rendered, regardless of any payments expected by an insurance company. I also understand and agree a late fee of $25.00 will apply if payment is not received on the agreed due date and additional charges will apply when poor patient cooperation is noted by the doctor.

Date _____ Signature _____

As of April 14, 2003, federal law requires us to give our patients a copy of our Notice of Privacy Practices. Please retain the attached copy of our policy concerning your health information. I have received a copy from this office of the Notice of Privacy Practices.

Date _____ Signature _____

A photocopy of this authorization shall be considered as valid as the original.