



# Welcome To Our Practice

JAMES E. LARSON DDS, MSD

Please take a few minutes to answer the following questions so we can better assist you with your dental care needs.

Today's Date \_\_\_\_\_ Birth Date \_\_\_\_\_ Patient Social Security # \_\_\_\_\_

Patient Name \_\_\_\_\_  
(Last Name) (First Name) (Initial)

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced  Separated

Patient Home Phone \_\_\_\_\_ Patient Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

### In case of emergency contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Home Phone \_\_\_\_\_ Emergency Work Phone \_\_\_\_\_

### PRIMARY INSURANCE

Individual responsible for this account \_\_\_\_\_  
(Last Name) (First Name) (Initial)

Relationship to patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Street address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Responsible Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

### ADDITIONAL INSURANCE

Insured Individuals Name \_\_\_\_\_  
(Last Name) (First Name) (Initial)

Relationship to patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Street address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I authorize my insurance company to pay to Greater Chattanooga Orthodontics all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the Greater Chattanooga Orthodontics to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment unless prior arrangements have been approved.**



# Personal Medical History



## MEDICATIONS

Please List Any Medications The Patient is Currently Taking

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## MEDICAL HISTORY ( PLEASE FILL OUT FOR CHILDREN AND ADULT PATIENTS )

Has the patient had any of the following?

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Difficulty Breathing           | <input type="checkbox"/> Heart Surgery / Pace Maker     | <input type="checkbox"/> Psychiatric Problems        |
| <input type="checkbox"/> Artificial Bones / Joints | <input type="checkbox"/> Drug / Alcohol Abuse           | <input type="checkbox"/> Hemophilia / Abnormal Bleeding | <input type="checkbox"/> Rheumatic / Scarlet Fever   |
| <input type="checkbox"/> Artificial Valves         | <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Hepatitis                      | <input type="checkbox"/> Severe / Frequent Headaches |
| <input type="checkbox"/> Asthma / Arthritis        | <input type="checkbox"/> Epilepsy / Seizures / Fainting | <input type="checkbox"/> High / Low Blood Pressure      | <input type="checkbox"/> Shingles                    |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Fever Blisters / Herpes        | <input type="checkbox"/> HIV +/- AIDS                   | <input type="checkbox"/> Sinus Problems              |
| <input type="checkbox"/> Cancer / Chemotherapy     | <input type="checkbox"/> Glaucoma                       | <input type="checkbox"/> Hospitalized For Any Reason    | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Congenital Heart Defects  | <input type="checkbox"/> Heart Attack / Stroke          | <input type="checkbox"/> Kidney Problems                | <input type="checkbox"/> Ulcers / Colitis            |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur                   | <input type="checkbox"/> Mitral Valve Prolapse          |  |

### Medical Questions

Is the patient currently under the care of a physician?  Yes  No

If Yes Reason \_\_\_\_\_

Have the patients adenoids or tonsils been removed?  Yes  No

If Yes When \_\_\_\_\_

Has puberty begun?  Yes  No

Has menstruation begun (girls)?  Yes  No

Patients current general health is:?  Good  Fair  Poor

### Dental Questions

Ever experienced pain / discomfort in the jaw area (TMJ)?  Yes  No

Does patient grind their teeth?  Yes  No

Have there been injuries to the:  Face  Mouth  Jaw

Does the patient brush his/her teeth daily?  Yes  No

Does the patient floss his/her teeth daily?  Yes  No

Does the patient have missing or extra permanent teeth?  Yes  No

Patients current dental health is:?  Good  Fair  Poor

### Does / did the patient have any of the following habits?

- Lip Sucking / Biting  Mouth Breathing  Nail Biting  Speech Problems  Thumb / Finger Sucking  Tongue Thrust

## CHECK DEGREE OF HABITS BELOW. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

	HEAVY	CASUAL	LIGHT	NONE		HEAVY	CASUAL	LIGHT	NONE		HEAVY	CASUAL	LIGHT	NONE
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar/Sugar Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the information i have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictist confidence and it is my responsibility to inform this office of any changes in my/my child's medical status. I will not hold Greater Chattanooga Orthodontics or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form.

I authorize the dental staff to perform any necessary dental services that me/my child may need during diagnosis and treatment with my informed consent

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Patient Commitment



**ORTHODONTIC CARE REQUIRES A CONSISTENT COMMITMENT TO HYGIENE AND MAINTENANCE. WE WANT TO MAKE SURE YOUR EXPERIENCE IS THE BEST IT CAN BE. AS YOU CONSIDER BRACES .... SOME THOUGHTS AND TIPS TO THINK ABOUT BEFORE STARTING ORTHODONTIC TREATMENT..**

How long will it take?

The actual treatment time will vary depending upon the amount of tooth movement necessary, the rate of growth of the patient, and the degree of cooperation by all parties involved. Most orthodontic treatment take about two years to complete. Easy cases may be completed in a year; difficult patients may take three or more years to finish. Your dentist is the best person to estimate the time needed. Successful, timely orthodontic treatment depends on full cooperation of the patient and their parents or guardian.

How often will we need to see the orthodontist?

Braces require constant adjustment in order to work. Generally you can plan on visiting the dentist once a month. Your doctor will determine when the next appointment will be made. Neglecting braces can permanently damage the teeth and gums, therefore failure to keep scheduled appointments will make it necessary for your doctor to remove the braces and stop treatment.

What type of special care will the braces need?

Patients wearing braces need to avoid hard or sticky foods. Chewing on pens, pencils or fingernails can also damage braces. Some foods that usually would be eaten whole (an apple for example) will need to be cut up into bite-sized pieces. Damaged braces will not only extend the treatment time and require additional dentist appointments, but can cause the teeth to be moved into the wrong position.

For many patients, the braces alone may not be enough to complete the necessary treatment. Many patients will be required to wear rubber bands along with the braces. Rubber bands must be put on several times a day.

It is very important that the teeth and gums are kept clean during treatment with braces. Lack of brushing and flossing everyday can cause severe and permanent damage to both the teeth and gums. Teeth can be discolored with permanent white or brown spots. Gums can be damaged to where they need surgery in order to be repaired. Your dentist and staff will teach the patient (and/or parent or guardian) how to keep the teeth, gums and braces in good condition.

Before braces can be put on the teeth, the patient will need to visit their regular dentist for an examination, cleaning, fluoride treatment and any necessary fillings. During orthodontic treatment, the patient will also need to continue to visit their family dentist for check-ups and cleansing every six months.

Damaged or neglected braces can cause serious damage to the teeth and gums. Therefore multiple broken or damaged braces, and/or a lack of daily brushing and flossing will require the dentist to remove the braces and stop the treatment.

# Patient Commitment (cont'd)



Will having braces hurt?

Many patients feel some minor discomfort for a few weeks when the braces are first put in their mouth. This is due to the cheeks and gums getting accustomed to the surfaces of braces. After each monthly adjustment, the teeth may be a bit sore for a couple of days. The pain is easily managed with the medication one takes for a headache. Most patients agree that the benefits of a beautiful smile are worth the minor discomfort of the braces.

How important is patient and family commitment to successful treatment with braces?

Successful orthodontic treatment is a two-way street. It takes cooperation and commitment on the part of the doctor and the patient and their family to ensure timely completion, and a pleasing, functional result. Your dentist should review with the family the information contained in this letter. It is the responsibility of your dentist to ensure that each patient is an appropriate candidate for braces since permanent damage can occur through abuse and/or neglected of the teeth and braces, your dentist will require a strong commitment on the part of both the patient as well as the parent or guardian before they will recommend that braces be started. Unless you can make a commitment to keep monthly appointments, limit the foods that should be eaten, brush and floss daily and keep appointments with your family dentist for check-ups and cleaning twice a year, you should delay this long term commitment until a later date.

**I understand the commitment it will take on the part of myself as well as the patient to ensure that the proposed orthodontic treatment is completed successfully, and in a timely fashion. If my child is a minor I have discussed with them their responsibility to avoid hard and sticky foods, keep all regularly scheduled appointments, follow all directions of their doctor, and perform the necessary daily brushing and flossing. I understand that 2 consecutive, or a total of 3 missed appointments; excessive loss or damage to the braces, inability to brush or floss the teeth daily, and/or failure to cooperate with the wearing of all appliance attachments will cause our dentist to stop treatment and remove the braces for good.**

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Signature of Parent or Guardian

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Today's Date

# Map and Directions



Our office is located in Chattanooga, Tennessee. We are located on Gunbarrel Road directly across from Panera Bread and the Target Shopping Center.

Our address is 1829 Gunbarrel Road, Suite A-1, Chattanooga TN 37421

## From Chattanooga

Merge onto I-75 N

Take Exit 3A to merge onto East Brainerd Road

Turn left at Gunbarrel Road

Office will be 3/4 mile on left with green roof.

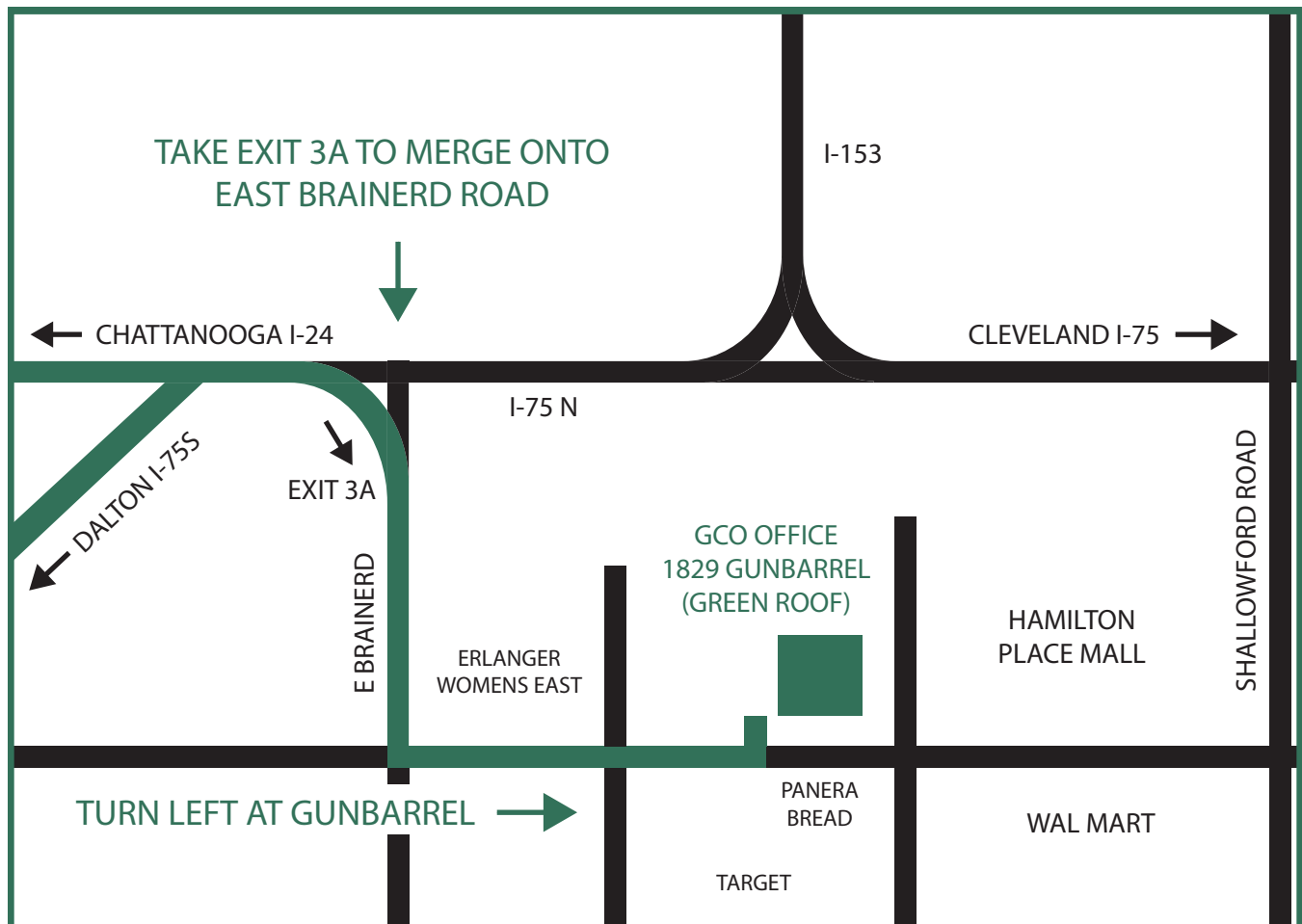
## From Dalton, Georgia

Take I-75 toward Knoxville at I-75 & I-24 Split

Take Exit 3A to merge onto East Brainerd Road

Turn left at Gunbarrel Road

Office will be 3/4 mile on left with green roof.



# GREATER CHATTANOOGA ORTHODONTICS

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## NOTICE OF PRIVACY PRACTICES

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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.

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### 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 affect. This notice takes effect April 14, 2003 and will remain in affect 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 anytime. 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.

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### USES AND DISCLOSURE 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 payments 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 payments 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 interferences 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 of 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 inmates 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).

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## 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 **\$0.25** for each page, **\$0.15** 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 at least 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 of 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 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-rmail), you are entitled to receive this Notice in written form,

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## 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: DIANNE ROOKS

TELEPHONE: (423) 296-0407

FAX: (423) 296-0174

EMAIL: [admin@gco-ortho.com](mailto:admin@gco-ortho.com)

ADDRESS: 1829 GUNBARREL ROAD, SUITE A-1, CHATTANOOGA TENNESSEE

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\*Note: You May Refuse to Sign This Acknowledgement\*

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I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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# GREATER CHATTANOOGA ORTHODONTICS

At Greater Chattanooga Orthodontics we care about your health and the health of all of our patients. In order to make your experience in orthodontic care the best it can be please note the two policies below. We have adopted these policies to contribute to and ensure the safe and efficient operation of our office as we serve you our patient.

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## ON-TIME POLICY FOR PATIENTS

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Thank you for allowing us to serve your orthodontic needs. We are glad to have you as a patient and want to make your experience as pleasant as possible. We know that a smooth operation on our part makes a much more pleasant experience for you working with a busy orthodontic office such as ours. One major key to running things smoothly is a very simple...

**WE HAVE TO STICK TO OUR APPOINTMENT SCHEDULE. THERE IS SIMPLY NO OTHER CHOICE.**

Anyone can have a bad day and need to miss a scheduled appointment. However, on-time patients are the ones who wind up being penalized when another patient is late and we do not want this to happen.

So, to make things work best for everyone, please note our policy:

**PLEASE CALL IF YOU ARE GOING TO BE MORE THAN 5 MINUTES LATE. IT IS EASIER FOR US TO WORK WITH YOU IF YOU CALL.**

**IF YOU ARE MORE THAN 15 MINUTES LATE FOR ANY REASON, YOU WILL HAVE TO BE RE-SCHEDULED TO THE NEXT AVAILABLE TIME SLOT, AS YOUR ORIGINAL APPOINTMENT TIME WILL HAVE PASSED BY THE TIME YOU ARRIVE.**

If we have a time slot available the same day, we will be happy to give it to you. If not, we will give you the next available time slot that we have on another day. **THERE WILL BE NO EXCEPTIONS TO THIS POLICY FOR ANY REASON.** Again, we thank you for allowing us to serve you. Our intention with this policy is to have a smoother running practice and to make your experience more predictable and pleasant.

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## PATIENT RESPONSIBILITY POLICY

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Patients and their guardians must understand the commitment it will take to ensure that the proposed orthodontic treatment is complete successfully and in a timely fashion, including the avoidance of hard and sticky foods; keeping all regularly scheduled appointments; following the doctor's directions and performing the necessary daily brushing and flossing.

Braces require constant adjustment and care in order to work. Generally, you can plan on visiting the orthodontist once a month. Your doctor will determine when the next appointment can and should be made. Broken or neglected braces can cause serious damage to teeth and gums. Therefore ... the doctor reserves the right to remove the braces and stop treatment if the patient fails to maintain proper hygiene, or repeatedly fails to keep scheduled appointments.

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**Once again we thank you for letting us serve you and for the observance of our office policies. If you have any questions about any policies or procedures please ask and one of our staff members will be happy to answer any concerns you may have.**

GREATER CHATTANOOGA ORTHODONTICS

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**RESPONSIBLE PARTY WAIVER OF RIGHTS  
OF PATIENT'S DIGITAL PHOTOS**

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Digital photos of patient's dentitions and facial profiles are generally used in orthodontic practices for marketing, promotional and educational purposes. By signing this waiver, you are giving Dr. Larson and Greater Chattanooga Orthodontics the rights to use your/your child's photos for these purposes and for only these purposes

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Patient Name-printed

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Responsible party-printed

\_\_\_\_\_ I hereby give the rights to GCO to use the intra-oral digital photos.  
intl

or

\_\_\_\_\_ I hereby give the rights to GCO to use the intra-oral facial and profile  
intl digital photos.

or

\_\_\_\_\_ I choose to reserve the rights (not to allow) the digital photos to be used and  
intl ask to have the photos remain only as a part of the patient record.

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Signature- Responsible Party

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Date

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Witnessed

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Date