PATIENT FORM

PATIENT INFORMATION

Last Name: .....

First Name: .....

Birth Date: ..... ☐ **M** ☐ **F** ☐ Other:

Address: .....

City/State/Zip: .....

Phone No. (s): .....

Email Address: .....

RESPONSIBLE PARTY

Last Name: .....

First Name: .....

Social Security No: .....

Birth Date: .....

Work Phone: .....

Employer: .....

Spouse's Name: .....

What are your concerns about Ortho Tx: ☐ **Pain** ☐ **Cost** ☐ **Aesthetics** ☐ **Other:** .....

DENTAL HEALTH

Name of Dentist: .....

Phone : .....

Date of Last Visit: .....

When were you last given dental x-ray? .....

Any pain or clicking when opening mouth? .....

Have you ever had any injuries to the mouth/jaw area? ☐ **YES** ☐ **NO**

Have you had orthodontic treament in the past? ☐ **YES** ☐ **NO**

If patient is a child: ☐ Thumb sucking ☐ Tongue Thrusting ☐ Mouth Breathing

DENTAL INSURANCE INFORMATION

Last Name: .....

First Name: .....

Subscriber ID/SSN: .....

Birth Date: .....

Insurance Company: .....

Group No / Plan no.: .....

Employer: .....

HEALTH QUESTIONAIRE

Name of Physician: .....

City: .....

Are you allergic to the following:

☐ N/A ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Latex ☐ Metal

Are you pregnant? ☐ N/A ☐ Yes ☐ No If yes, How many months? .....

Have you been hospitalized in the last two years? ☐ Yes ☐ No

If yes, explain: .....

List any other medical conditions you feel the doctor should be aware of:

.....

DENTAL INSURANCE INFORMATION

Last Name: .....

First Name: .....

Subscriber ID/SSN: .....

Birth Date: .....

Insurance Company: .....

Group No / Plan no.: .....

Employer: .....

Please check one box for each item below.

	YES	NO		YES	NO
Anemia	☐	☐	**HIV/AIDS**	☐	☐
Asthma	☐	☐	**Jaw/TMJ Pain/TMD**	☐	☐
Cancer/Tumors	☐	☐	**Kidney Diseases**	☐	☐
Diabetes	☐	☐	**Skin Problems**	☐	☐
Seizures	☐	☐	**Rheumatic Fever**	☐	☐
Fainting/Dizziness	☐	☐	**Radiation Treatment**	☐	☐
Growth Problems	☐	☐	**Liver Disease /Hepatitis**	☐	☐
Heart Problems/Diseases	☐	☐	**Speech Difficulties**	☐	☐
Heart Murmur	☐	☐	**Bisphosphate**	☐	☐

ACKNOWLEDGEMENT

I have read and understood the questions above. I hereby certify the information provided is complete and accurate to the best of my knowledge. Should there be any changes to my personal information, dental and medical health, I will notify my orthodontist.

I authorize the release information regarding my orthodontic treatment to my dental and/or medical insurance company.

I understand that where appropriate, credit bureau reports may be obtained.

.....

Signature of Responsible Party

....

Relationship to Patient **Date**

OFFICE USE: P1 P2 INV UL U L ULC UC LC APP EXT RET

....

Doctor's Signature **Date**

Alexandra Chang, DDS, MS

Notice of Privacy Policies and Practices

Dear Patient:

This notice describes how medical/dental information about you may be used and disclosed, and how you can get access to this information.

PLEASE REVIEW THIS NOTICE CAREFULLY

We are committed to protecting medical/dental information about you/your child/ward. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information.

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following:

- ❖ To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you, for example, to determine the results of cleanings, surgery, etc.);
- ❖ To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- ❖ To certifying, licensing, and accrediting bodies (i.e., the American Board of Orthodontics, State Dental Boards, etc.) in connection with obtaining certification, licensure or accreditation;
- ❖ Internally, to all staff members who have any role in your treatment;
- ❖ To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- ❖ To your family and close friends involved in your treatment; and/or,
- ❖ We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

YOUR RIGHTS

Under the new privacy rules, you have the right to the following:

- ➢ Request restrictions on the use and disclosure of your protected health information;
- ➢ Request confidential communication of your protected health information;
- ➢ Inspect and obtain copies of your protected health information through asking us;
- ➢ Amend or modify your protected health information in certain circumstances;
- ➢ Receive an accounting of certain disclosures made by us of your protected health information, and;

You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary Health and Human Services, which must be filed within 180 days from the violation.

OUR RESPONSIBILITIES

We have the following duties under the privacy rules:

- ♦ By law, to maintain the privacy protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- ♦ To abide by the terms of our Privacy Notice that is currently in effect;
- ♦ To advise you of our rights to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to the following:

- ♦ Honor any request by you to restrict the use or disclosure of your protected health information.
- ♦ Amend your protected health information if, for example, it is accurate and complete; or,
- ♦ Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties

HEALTH INFORMATION USE AND/OR DISCLOSURE

Your health information is used for treatment, and may be used by staff members or disclosed to other health care professionals to evaluate your health, diagnose medical/dental conditions, and provide care. We may also provide a licensed, credentialed, substitute health care provider, authorized by this practice, to provide assessment and/or treatment to our patients, without advance notice, in the event of your primary health care provider's absence due to sickness, vacation, or other situations.

COMMUNICATION WITH FAMILY

Due to the nature of our field, we will use our best judgment when disclosing health information to family members, other relatives, or any other persons involved in your/your child's/ward's care that you have authorized to receive this information. Please inform the Practice when you do not wish a family member or other individual to have authorization to receive such information. In those situations, when there is disputed custody or multiple payers, this may complicate the administrative process and delay our abilities to provide care until proper documentation is obtained so that such issues are addressed appropriately with all relevant agencies and/or parties involved.

BUSINESS ASSOCIATES

In some instances, we have contacted separate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a dental/medical laboratory, technical representatives, answering services, computer software/hardware providers, billing service, collection agency, and insurance agents/underwriters.

LAW ENFORCEMENT

Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting, court order or subpoena.

OTHER USES AND DISCLOSURES

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. Your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision

CHANGE OF OWNERSHIP

In the event that this practice is sold or merged with another organization, your health information/records will become the property of the new owner.

APPOINTMENT REMINDERS

The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by email, text message (may be a fee from your cellular phone carrier), mail, or a brief, non-specific message may be left on your answering machine/phone service. If you do not approve of these methods, or if you prefer alternative methods, please inform our office/practice.

ACKNOWLEDGEMENT

This privacy notice is effective of the date of your signature. If you have any questions about the information in this Privacy Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Signature (Parent/Guardian, if minor)	Date
Patient Name	Relationship to Patient