(Adult Patient)

Welcome

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank You!

Patient Information

Marital Status ❍ Single ❍ Married ❍ Divorced ❍ Widowed ❍ Significant Other

Patient Name _____ ❍ Male ❍ Female
(First) (Middle) (Last)

Social Security Number _____ Birth Date _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ ❍ Home ❍ Cell Ok to Leave Message? ❍ Yes ❍ No

Secondary Phone Number _____ ❍ Home ❍ Cell Ok to Leave Message? ❍ Yes ❍ No

E-mail _____

Employer's Name _____ Occupation _____ Phone Number _____

Spouse / Partner Information

Name _____ Birth Date _____
(First) (Middle) (Last)

Home Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ ❍ Home ❍ Cell

Secondary Phone Number _____ ❍ Home ❍ Cell

Employer's Name _____ Occupation _____ Phone Number _____

Emergency Contact Information

Emergency Contact Name _____

Phone Number _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Insurance Information

Primary Insurance Company _____ Phone Number _____

Group Number _____ Policy Number _____ Member ID Number _____

Policy Holder's Name _____ Relation _____

Policy Holder's SSN _____ Policy Holder's Date of Birth _____

Employer _____ Work Phone Number _____

Secondary Insurance Company _____ Phone Number _____

Group Number _____ Policy Number _____ Member ID Number _____

Policy Holder's Name _____ Relation _____

Policy Holder's SSN _____ Policy Holder's Date of Birth _____

Employer _____ Work Phone Number _____

Dental History

General Dentist _____ Last Visit _____

How did you hear about our practice? O Ad O Internet O Family/Friend O Physician O Dentist O Other

Name of Person Referring (If Applicable) _____

What are the main concerns you would like Orthodontics to accomplish?

Concerns _____

Have you had an Orthodontic Consultation before? O Yes O No

Have you had Orthodontic treatment before? O Yes O No

When _____ Reason _____

Have your tonsils or adenoids been removed? O Yes O No

Have you ever experienced jaw joint pain / discomfort (TMJ/TMD)? O Yes O No

Do you have any missing or extra permanent teeth? O Yes O No

Have you ever had an injury to (select all that apply)? O Teeth O Mouth O Chin

Do you have speech problems? O Yes O No

If so, explain _____

Do your gums bleed? O Yes O No Do you smoke? O Yes O No Do you chew tobacco? O Yes O No

Do you currently or have you ever had any of the following habits (check all that apply)?

O Clenching / Grinding Teeth O Lip Sucking / Biting O Mouth Breathing
O Nail Biting O Thumb / Finger Sucking O Chewing / Eating Problem

Medical History

Are you currently being treated by a physician O Yes O No

Reason _____ Physician _____

Last Visit _____ Phone _____

Do you have any allergies / sensitivities to medications? O Yes O No

If yes, please list _____

Do you have any allergies / sensitivities to Latex? O Yes O No

Are you currently taking any prescription or over-the-counter medications? O Yes O No

Please list, with dosage _____

Have you ever had any serious illnesses or operations? O Yes O No

If yes, describe _____

(Women) Are you pregnant? O Yes O No Nursing? O Yes O No Taking Birth Control Pills? O Yes O No

Check if you have ever had any of the following:

O ADD/ADHD	O Circulatory Problems	O Hemophilia	O Scarlet Fever
O Anemia	O Cortisone Treatments	O Hepatitis	O Shortness of Breath
O Arthritis, Rheumatism	O Cough, Persistent	O High Blood Pressure	O Skin Rash
O Artificial Heart Valves	O Coughing Blood	O HIV/AIDS	O Stroke
O Artificial Joints	O Diabetes	O Kidney Disease	O Swelling of Feet or Ankles
O Asthma	O Epilepsy	O Liver Disease	O Thyroid Problems
O Back Problems	O Fainting	O Mitral Valve Prolapse	O Tonsillitis
O Blood Disease	O Glaucoma	O Pacemaker	O Shortness of Breath
O Cancer	O Headaches	O Radiation Treatment	O Tuberculosis
O Chemical Dependency	O Heart Murmur	O Respiratory Disease	O Ulcer
O Chemotherapy	O Heart Problems	O Rheumatic Fever	

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.

I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payments of any benefits to the office.

Submitted by _____ Date _____

Name: _____ Date_____

Patient's Name

Feller & Feller
ORTHODONTICS

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. (The above information is a general HIPPA required statement for all health care offices).

Uses and Discloses of Protected Health Information

Your protected health information may be used and disclosed by your physician/dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's/dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician/dentist to whom you have been referred to ensure that the physician/dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for the health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's/dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician/dentist. We may also call you by name in the waiting room when your physician/dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosures: Under law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician/dentist or the physician's/dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or a use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. (If applicable)

I request that my protected health information (or my child) not be disclosed to: _____

Your physician/dentist is not required to agree to a restriction that you may request. If the physician/dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You may have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician/dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature:_____

Relationship to Patient: _____Date:_____