AUSTIN FAMILY ORTHODONTICS

www.austinfamilyorthodontics.com

New Patient Information

Patient's Name: _____
last first middle likes to be called

Date of Birth: _____ Age: _____ Gender: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home telephone #: _____ Cell #: _____ other #: _____

Marital Status for adult patients only: ○ Single ○ Married ○ Divorced

Do we see other family members? ○ Yes ○ No If yes, please list their names: _____

Patients School: _____

Patients Hobbies/Interests: _____

Does the Patient play a Musical Instrument? ○ Yes ○ No if yes, please list what type: _____

Whom may we thank for referring you to our office? ○ Dr. _____ ○ Insurance Website

○ Phone Book ○ Walk in ○ Relative _____ ○ Friend _____ ○ Other _____

Parent Information (If patient is a minor)

○ Father ○ Stepfather ○ Guardian ○ Single ○ Married ○ Divorced

Name: _____ DOB: _____ SSN: _____
last first middle

Employer: _____ Work #: _____

Address (if different from patient): _____ City: _____ State: _____ Zip: _____

Home telephone #: _____ Cell #: _____ other #: _____

E-mail address: _____

○ Mother ○ Stepmother ○ Guardian ○ Single ○ Married ○ Divorced

Name: _____ DOB: _____ SSN: _____
last first middle

Employer: _____ Work #: _____

Address (if different from patient): _____ City: _____ State: _____ Zip: _____

Home telephone #: _____ Cell #: _____ other #: _____

E-mail address: _____

Do you have legal custody of this child? _____

Emergency Contact: _____ Relationship: _____

Home telephone #: _____ Cell #: _____ other #: _____

Dental Insurance Information and Financial Responsibility

Person Responsible for Account: _____
last first middle

Relationship to Patient:_____ DOB: _____ SSN:_____

Address (if different from patient):_____
street city state zip

Phone:_____Cell Phone/Alternate Phone: _____

Primary Insurance Holder Employed by: _____ Occupation:_____

Primary Dental Insurance Company: _____

Primary Dental Insurance Company Address: _____

Contact #: _____ Group #:_____ Subscriber ID:_____

Secondary Insurance Holder Employed by: _____ Occupation: _____

Secondary Dental Insurance Company: _____

Secondary Dental Insurance Company Address: _____

Contact #: _____ Group #:_____ Subscriber ID: _____

Dental History

What is your primary concern today? _____

How often do you brush: _____floss: _____

Patient's Dentist:_____Date of your last dental cleaning? _____

Is any dental work pending?_____

Ever had a prior orthodontic examination or treatment? ○ Yes ○ No If Yes, with who? _____

Now or in the past, has the patient had:

yes	no	dk/u	(don't know/understand)
○	○	○	Have you ever been treated for "TMD" or "TMJ" problems?
○	○	○	Any pain or soreness in the muscles of the face or around the ears?
○	○	○	Tooth grinding or jaw clenching?
○	○	○	Difficulty in chewing or jaw opening?
○	○	○	Any pain, clicking or locking in jaw or ringing in the ears?
○	○	○	Aware or concerned about under or over developed jaw?
○	○	○	Periodontal "gum problems"?
○	○	○	Had periodontal (gum) treatment?
○	○	○	"Gum boils", frequent canker sores or cold sores?
○	○	○	Jaw fractures?
○	○	○	Mouth cysts?
○	○	○	Mouth infections?
○	○	○	Permanent or "extra" (supernumerary) teeth removed?
○	○	○	"Dead teeth" or root canals treated?

yes	no	dk/u	(don't know/understand)
○	○	○	Thumb, finger, or sucking habit? Until what age?_____
○	○	○	Abnormal swallowing habit (tongue thrusting)?
○	○	○	Mouth breathing habit, snoring or difficulty in breathing?
○	○	○	History of speech problems?
○	○	○	Any relative with similar tooth or jaw relationships?
○	○	○	Any teeth irritating cheek, lip, tongue or palate?
○	○	○	Teeth sensitive to hot or cold; teeth throb or ache?
○	○	○	Any wisdom tooth problems?
○	○	○	Chipped or otherwise injured primary (baby) or permanent teeth?
○	○	○	Aware of loose, broken or missing restorations (fillings)?
○	○	○	Food impaction between teeth?
○	○	○	Supernumerary (extra) or congenitally missing teeth?

Any additional information not already covered? _____

_____

Medical History

For the following questions mark 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.

Patients Physician: _____ Contact #: _____

Are you in good general health?_____

Have you ever been told to take premedication before a dental visit? _____

Medical Conditions

Now or in the past, have you had:

yes	no	dk/u	(don't know/understand)
○	○	○	Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease, mitral valve prolapse?)
○	○	○	High or low blood pressure?
○	○	○	Bacterial endocarditis
○	○	○	Hay fever, asthma, sinus trouble or hives
○	○	○	Rheumatoid or arthritic conditions?
○	○	○	Kidney problems?
○	○	○	Cancer, tumor, radiation treatment or chemotherapy?
○	○	○	Polio, mononucleosis, tuberculosis, pneumonia?
○	○	○	AIDS or HIV positive?
○	○	○	Fainting spells, seizures, epilepsy or neurological problem?
○	○	○	Vision, hearing, tasting or speech difficulties?
○	○	○	History of eating disorder (anorexia, bulimia)?
○	○	○	Chest pain, shortness of breath or swelling ankles?
○	○	○	Skin disorder?
○	○	○	Frequent headaches, colds or sore throats?
○	○	○	Eye, ear, nose or throat condition?
○	○	○	Tonsil or adenoid conditions?
○	○	○	Anemia or bleeding/disorder?

yes	no	dk/u	(don't know/understand)
○	○	○	Sickle Cell disease/trait
○	○	○	Bone fractures, any major accidents?
○	○	○	Endocrine or thyroid problems?
○	○	○	Diabetes?
○	○	○	Stomach ulcer or hyperacidity?
○	○	○	Problems of the immune system?
○	○	○	Hepatitis, jaundice or liver problem?
○	○	○	Mental health disturbance or depression?
○	○	○	Loss of weight recently, poor appetite?
○	○	○	Excessive bleeding or bruising tendency?
○	○	○	Birth defects or hereditary problems?
○	○	○	Cleft Lip/Palate?

Allergies or reactions to any of the following:

○	○	○	Latex (gloves, balloons)
○	○	○	Metals (Nickel, Etc…)
○	○	○	Other substances (specify) _____
○	○	○	Are you taking medication, nutrient supplements.

Women Only:

○	○	○	Are you pregnant?

Explain: _____

_____

Prescription medications or non prescription medication?

Medication _____Taken for _____

Medication _____Taken for _____

Medication _____Taken for _____

Any other medical conditions that we should know about? _____

_____

Authorization and Release:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in my child's medical or dental status. I give my permission to the dentist to obtain any additional information from the patient's physician regarding the medical history. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to third party payers' and/or other health practitioners.

Signature of Patient/Parent/Guardian:_____ Date: _____

Printed Name:_____ Relationship: _____

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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

(HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT REQUIREMENT)

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

NAME OF PATIENT:_____

PERSONAL REPRESENTATIVE'S NAME:_____

RELATIONSHIP TO PATIENT:_____

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 effect.

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 available 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.

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 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 payment 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, 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 the 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 inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms for 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. 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 to 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 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 massages, postcards, or letters).

PATIENT RIGHTS

Access: You have access to 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 practically 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 $25. 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 the last 6 years. 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 the alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, 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-mail), you are entitled to receive this Notice in written form.

I, (Print)_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, **I AM GIVING MY CONSENT** to you to use and disclose of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:_____ Date:_____

REVOCATION OF CONSENT
I REVOKE MY CONSENT for our use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date:_____

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 your 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: Debbie Mazuca

Telephone: 512-258-9007 Fax: 512-258-1615
Address: 12501 Hymeadow Dr. Suite 1D Austin, TX 78750

Telephone: 512-258-9007 Fax: 512-248-8842
Address: 893 North IH35 #110 Round Rock, 78664