NEW Adult Patient Information

VICTORIA PEDIATRIC DENTISTRY & ORTHODONTICS

Patient Information

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

Date of Birth: _____ Age: _____ Sex: _____ E-Mail: _____

Phone: _____ Cell Phone/Alternate Phone: _____

Home Address: _____
street city state zip

Marital Status: ¢ single ¢ married ¢ separated ¢ divorced ¢ remarried ¢ widowed

Patient's Dentist: _____ Referred By: _____ Physician: _____

Names & Ages of Children: _____

_____

Occupation: _____ Work Phone: _____

Employed By: _____

Spouse's Name: _____ Work Phone: _____

Occupation: _____ Employed By: _____

Responsible Party Information

Person Responsible for Account _____
last first middle

Relationship to Patient: _____ Birth date: _____ Soc. Sec. #: _____

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

Phone: _____ Cell Phone/Alternate Phone: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____
street city state zip

Does the patient have dental Insurance coverage? Yes or No

Dental Insurance Company: _____

Address: _____ Contact #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber #: _____ Group #: _____

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.

Now or in the past, have you had:

yes no dk/u (don't know/understand)

- ¢ ¢ ¢ Birth defects or hereditary problems?
- ¢ ¢ ¢ Bone fractures, any major accidents?
- ¢ ¢ ¢ Rheumatoid or arthritic conditions?
- ¢ ¢ ¢ Endocrine or thyroid problems?
- ¢ ¢ ¢ Kidney problems?
- ¢ ¢ ¢ Diabetes?
- ¢ ¢ ¢ Cancer, tumor, radiation treatment or chemotherapy?
- ¢ ¢ ¢ Stomach ulcer or hyperacidity?
- ¢ ¢ ¢ Polio, mononucleosis, tuberculosis, pneumonia?
- ¢ ¢ ¢ Problems of the immune system?
- ¢ ¢ ¢ AIDS or HIV positive?
- ¢ ¢ ¢ Hepatitis, jaundice or liver problem?
- ¢ ¢ ¢ Fainting spells, seizures, epilepsy or neurological problem?
- ¢ ¢ ¢ Mental health disturbance or depression?
- ¢ ¢ ¢ Vision, hearing, tasting or speech difficulties?
- ¢ ¢ ¢ Loss of weight recently, poor appetite?
- ¢ ¢ ¢ History of eating disorder (anorexia, bulimia)?
- ¢ ¢ ¢ Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- ¢ ¢ ¢ High or low blood pressure?
- ¢ ¢ ¢ Tired easily?
- ¢ ¢ ¢ Chest pain, shortness of breath or swelling ankles?
- ¢ ¢ ¢ Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- ¢ ¢ ¢ Skin disorder?
- ¢ ¢ ¢ Do you have a well-balanced diet?
- ¢ ¢ ¢ Frequent headaches, colds or sore throats?
- ¢ ¢ ¢ Eye, ear, nose or throat condition?
- ¢ ¢ ¢ Hayfever, asthma, sinus trouble or hives?
- ¢ ¢ ¢ Tonsil or adenoid conditions?
- ¢ ¢ ¢ Osteoporosis?

Allergies or reactions to any of the following:

- ¢ ¢ ¢ Local anesthetics (Novocaine or Lidocaine)
- ¢ ¢ ¢ Aspirin
- ¢ ¢ ¢ Ibuprofen (Motrin, Advil)
- ¢ ¢ ¢ Penicillin or other antibiotics
- ¢ ¢ ¢ Sulfa drugs
- ¢ ¢ ¢ Codeine or other narcotics
- ¢ ¢ ¢ Metals (jewelry, clothing snaps)
- ¢ ¢ ¢ Latex (gloves, balloons)
- ¢ ¢ ¢ Vinyl
- ¢ ¢ ¢ Acrylic
- ¢ ¢ ¢ Animals
- ¢ ¢ ¢ Foods (specify) _____
- ¢ ¢ ¢ Other substances (specify) _____

yes no dk/u (don't know/understand)

- ¢ ¢ ¢ Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for _____

yes no dk/u (don't know/understand)

- ¢ ¢ ¢ Do you currently have or ever had a substance abuse problem?
- ¢ ¢ ¢ Do you chew or smoke tobacco?
- ¢ ¢ ¢ Operations? Describe: _____
- ¢ ¢ ¢ Hospitalized? For: _____
- ¢ ¢ ¢ Other physical problems or symptoms? Describe: _____
- ¢ ¢ ¢ Being treated by another health care professional? For: _____ Date of most recent physical exam? _____
- ¢ ¢ ¢ Do you have any other medical conditions that we should know about?

Women Only:

- ¢ ¢ ¢ Are you pregnant?
- ¢ ¢ ¢ Are you anticipating becoming pregnant?

Family Medical History:

Do your parents or siblings have, or have ever had any of the following health problems? If so, please explain.

¢ Bleeding disorders ¢ Diabetes ¢ Arthritis
¢ Severe allergies ¢ Unusual dental problems
¢ Jaw size imbalance

Any other family medical conditions that we should know about? _____

Dental History

Now or in the past, has the patient had:

yes no dk/u (don't know/understand)

- ¢ ¢ ¢ Permanent or "extra" (supernumerary) teeth removed?
- ¢ ¢ ¢ Supernumerary (extra) or congenitally missing teeth?
- ¢ ¢ ¢ Chipped or otherwise injured primary (baby) or permanent teeth?
- ¢ ¢ ¢ Teeth sensitive to hot or cold; teeth throb or ache?
- ¢ ¢ ¢ Jaw fractures, cysts or mouth infections?
- ¢ ¢ ¢ "Dead teeth" or root canals treated?
- ¢ ¢ ¢ Bleeding gums, bad taste or mouth odor?
- ¢ ¢ ¢ Periodontal "gum problems"?
- ¢ ¢ ¢ Food impaction between teeth?
- ¢ ¢ ¢ "Gum boils", frequent canker sores or cold sores?
- ¢ ¢ ¢ Thumb, finger, or sucking habit? Until what age? ____
- ¢ ¢ ¢ Abnormal swallowing habit (tongue thrusting)?
- ¢ ¢ ¢ History of speech problems?
- ¢ ¢ ¢ Mouth breathing habit, snoring or difficulty in breathing?
- ¢ ¢ ¢ Tooth grinding or jaw clenching?
- ¢ ¢ ¢ Any pain, clicking or locking in jaw or ringing in the ears?
- ¢ ¢ ¢ Any pain or soreness in the muscles of the face or around the ears?

yes no dk/u (don't know/understand)

- ¢ ¢ ¢ Difficulty in chewing or jaw opening?
- ¢ ¢ ¢ Have you ever been treated for "TMD" or "TMJ" problems?
- ¢ ¢ ¢ Aware of loose, broken or missing restorations (fillings)?
- ¢ ¢ ¢ Any teeth irritating cheek, lip, tongue or palate?
- ¢ ¢ ¢ Concerned about spaced, crooked or protruding teeth?
- ¢ ¢ ¢ Aware or concerned about under or over developed jaw?
- ¢ ¢ ¢ Any relative with similar tooth or jaw relationships?
- ¢ ¢ ¢ Any wisdom tooth problems?
- ¢ ¢ ¢ Had periodontal (gum) treatment?
- ¢ ¢ ¢ Had any serious trouble associated with any previous dental treatment?
- ¢ ¢ ¢ Been under another dentist's care?
  Specialist _____
  Other _____
- ¢ ¢ ¢ Ever had a prior orthodontic examination or treatment?
- ¢ ¢ ¢ Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: _____ floss: _____

What is your primary concern? _____

Why are you here? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed _____
(Dental staff member)

NOTICE OF PRIVACY PRACTICES

Victoria Pediatric Dentistry & Orthodontics
7002 Zac Lentz Parkway
Victoria, TX 77904
(361) 433-4704

Privacy Officer: Teresa Booker

Effective Date: March 17, 2017

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical/ dental information. We make a record of the dental care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality dental care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this dental practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical/ dental information. It also describes your rights and our legal obligations with respect to your medical/ dental information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Dental Practice May Use or Disclose Your Health Information

This dental practice collects health information about you and stores it in a chart [and/or on a computer][and in an electronic health record/personal health record]. This is your dental record. The dental record is the property of this dental practice, but the information in the dental record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical/ dental information about you to provide your dental care. We disclose medical/ dental information to our employees and others who are involved in providing the care you need. For example, we may share your medical/ dental information with other dentists or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical/ dental information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical/ dental information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical/ dental information about you to operate this dental practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your dental plan to authorize services or referrals. We may also use and disclose this information as necessary for dental reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical/ dental information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or dental plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical/ dental information to contact and remind you

about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical/ dental information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation, which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical/ dental information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying

or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we may be required make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this dental practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another dentist or dental group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

20. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Dental Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this dental practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this dental practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical/ dental information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your

child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this dental practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this dental practice, except that this dental practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this dental practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this dental practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region VI - Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)

Jorge Lozano, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

Voice Phone (800) 368-1019
FAX (214) 767-0432
TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf

You will not be penalized in any way for filing a complaint.

VICTORIA
PEDIATRIC DENTISTRY
& ORTHODONTICS

Privacy Consent

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

_____

Patient's Signature

_____

Print Name

_____

Date

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

_____

Personal Representative's Name:

_____

VICTORIA
PEDIATRIC DENTISTRY
& ORTHODONTICS

Acknowledgement of Receipt of Notice of Privacy Practices

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

Print Name

_____

Signature

_____

Date

_____

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)

_____

_____

_____