DRS. ALLEN & ALLEN

Orthodontics for Children and Adults

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PATIENT'S INFORMATION

Patient's Full Name _____ Nickname _____ Date _____
(First, Middle, Last)

Patient's Address _____
(Street, Apt. No., City, State, Zip)

Patient's School _____ Email _____

Patient's Date of Birth _____ Age _____ ☐ Male ☐ Female ☐ Single ☐ Married
(Month, Day, Year)

Patient's Dentist _____ Date last visited _____
(Name, City, State)

Whom may we thank for referring you: _____

Name's and age(s) of children or siblings: _____

Has any member of the family undergone orthodontic treatment? _____

RESPONSIBLE PARTY INFORMATION

Name _____ Home Phone _____ Cell Phone _____
(First, Middle, Last)

Home Address _____ For how long _____
(Street, Apt. No., City, State, Zip)

Your relationship to patient _____ Texas D.L. No. _____ Your Birth Date _____

Your Employer _____ Social Security No. _____

Your Occupation _____ Work Phone _____ No. of years employed _____

Spouse's Name _____ Spouse's Employer _____
(First, Middle, Last)

Spouse's Occupation _____ Work Phone _____

Nearest Relative Not Living With _____ Phone _____

HEALTH HISTORY

Medical History **Updates** _____ _____ _____

Please check if patient has, or has had. . .

- ☐ Joint Swelling or Arthritis
- ☐ Bone Disorders
- ☐ Heart Problems
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Rheumatic Fever
- ☐ Hepatitis or Liver Problems
- ☐ Emotional Problems
- ☐ Tuberculosis
- ☐ AIDS (Acquired Immune Deficiency Syndrome)
- ☐ Anemia
- ☐ Asthma
- ☐ Epilepsy
- ☐ Prolonged Bleeding
- ☐ Endocrine Problems
- ☐ Tonsils Removed? If yes, when? _____
- ☐ Adenoids Removed? If yes, when? _____

List any Allergies: _____

_____

Is the patient under a physician's care presently? _____

Name _____

Reason _____

List any medication being taken presently: _____

_____

List any other serious illness and operations not listed above: _____

Dental History

Please check if patient has, or has had. . .

- ☐ Any injuries to face, mouth, teeth? (Circle)
- ☐ Thumb, finger or lip sucking habit(s)? (Circle)
- ☐ Any speech problems?
- ☐ Mouth breathing when asleep, awake? (Circle)
- ☐ Any known missing permanent teeth?
- ☐ Any known extra permanent teeth?
- ☐ Any teeth removed by extraction? When? _____
- ☐ Is there a tongue thrust problem?
- ☐ Any wind instruments played?
- ☐ Any clenching or grinding of teeth? (Circle)
- ☐ Any chronically sore or bleeding gums?
- ☐ Any pain, popping or locking on opening or closing jaw movement? (Circle)
- ☐ Any difficulty in chewing or swallowing food? (Circle)
- ☐ Frequent Headaches? If yes, headaches per week? _____
- ☐ Any muscle tenderness or stiffness in the jaw or neck? (Circle)
- ☐ Any ringing sounds in the ear, or spells of dizziness? (Circle)
- ☐ Any previous treatment for TMJ or jaw joint problems? If yes, explain.

_____

_____

Does patient visit his/her dentist regularly? _____

Has an orthodontist been consulted previously? _____

Reason _____

Has the patient experienced a sudden increase in height? ☐ Yes ☐ No

Does any member of the family or close relatives have similar arrangement of teeth or similar appearance of jaws? _____

_____

Pleae list your chief concern(s) and what you would like treatment to accomplish: _____

_____

INSURANCE BENEFITS SUMMARY

At this time, as a courtesy to our patients, our office will file your insurance. Prior to your initial appointment you will need to call your insurance company to obtain your quoted orthodontic benefits with the following information:

Lifetime Maximum: $_____

Annual Maximum (if any): $_____

Percentage of Payout: _____%

Benefits Remaining: $_____

Age Limitations: _____

Any Exclusions (waiting period) _____

INSURANCE INFORMATION

Patient's Name: _____ Date of Birth: _____

Insured's Name: _____ Insured's SS# _____

Insured's Employer: _____ Occupation: _____

Insurance Company: _____ Phone #: _____

Insurance Co. Address: _____ Group #: _____
Address
_____ Policy #: _____
City, State Zip
Effective Date: _____

SECONDARY INSURANCE INFORMATION**

Patient's Name: _____ Date of Birth: _____

Insured's Name: _____ Insured's SS# _____

Insured's Employer: _____ Occupation: _____

Insurance Company: _____ Phone #: _____

Insurance Co. Address: _____ Group #: _____
Address
_____ Policy #: _____
City, State Zip
Effective Date: _____

INSURANCE BENEFITS SUMMARY cont'd

Thank you for providing this information for us so that we can be efficient in caring for your insurance benefits. We appreciate you considering Allen & Allen Orthodontics for your or your child's precious smile. We will do our best to honestly maximize your orthodontic benefits.

I understand that the information I have been given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform any necessary orthodontic services that I may need during diagnosis and treatment with my informed consent.

Signature **Date**

Allen and Allen Orthodontics -
Garland
5435 N. Garland Avenue
Suite 125
Garland
Texas, 75040

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Allen and Allen Orthodontics - Garland understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 This Notice takes effect 01/07/2020, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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 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 may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which 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 another 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, 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 inferences 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 purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy 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 inmate or patient under certain circumstances.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

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, mailing, 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 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 the last 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 or 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 at 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.

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 by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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.

Privacy Officer: Lydia Tamez
Telephone: 972-772-2500
E-mail: treatmentcoord@allenortho.com
Address: 5435 N. Garland Avenue
Suite 125
Zip Code: 75040
State: Texas
City: Garland

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However such a revocation will not be retroactive.

By signing this form, I understand that:

____Protected health information may be disclosed or used for treatment, payment, or healthcare operation

____The practice reserves the right to change the privacy policy as allowed by law

____The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions

____The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease

____The practice may condition receipt of treatment upon execution of this consent

May we phone you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell? YES NO

May we leave a message at your employment? YES NO

May we email to your specified email address personal private health information including but not limited to laboratory reports, treatment recommendations, relevant scientific articles and medical forms? YES NO

May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

_____

_____

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____