Orthodontic Associates

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DATE: _____

OFFICE: _____

ACCOUNT #: _____

PATIENT INFORMATION

Patient's Name: _____

Birth Date: _____ Age: _____ Sex: M____ F____

Home Address: _____

City/State: _____ Zip: _____

Primary Phone: _____

Business Phone: _____

Cell Phone: _____

Fax: _____

E-Mail: _____

Patient's Employer or School: _____

Number of Siblings: _____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party: _____

Relationship to Patient: _____

Home Address: _____

City/State: _____ Zip: _____

Primary Phone: _____

Business Phone: _____

Cell Phone: _____

Fax: _____

E-Mail: _____

Employer: _____

Social Security #: _____ DOB: _____

INSURED'S INFORMATION

- No is patient covered by insurance for orthodontic treatment? Group # _____
  - If Yes, insurance company name _____
- Insured Name _____ Insured Soc. Sec. # _____ Insured DOB: _____
- In case of Emergency contact: _____ Phone: _____
- Family Dentist: _____ Phone: _____ Physician: _____
- Which best describes how you first heard about our office? (Check one)

  ____ dentist ____ dental school ____ friend ____ another orthodontist ____ phone book

  ____ mailer ____ other, please describe _____
  - If you were referred by a friend, whom should be thank? _____

MEDICAL HISTORY

Has the patient ever had: (Please circle "Y" for yes or "N" for no)

						No	Heart Disease
Yes	A.I.D.S.	Yes	Auto Immune	No	Epilepsy	No	Hepatitis
Yes	A.I.D.S. Related Complex	Yes	Bleeding	No	Endocrine Problems	No	Herpes
Yes	Anemia	No	Blood Disease	No	Emotional Problems	No	HIV
Yes	Artificial Prosthesis	No	Bone Disorders	No	Head or Face Injury	No	Nervous Disorders
Yes	Asthma	No	Diabetes	No	Hearing Disorder	No	Rheumatic Fever

Other (describe): _____

Comments: _____

Yes Has the patient been under the care of a physician during the past two years, other than for routine examination?

Condition: _____

Drugs or medication currently being used: _____

Birth Defects: _____

No Has the patient reached puberty (menstruation, hair)?

RESPIRATORY HISTORY

Does the patient:

1. Have allergies to: Seasonal grasses: No Food: No
   Drugs: No (If yes, list drugs): Other: _____
   _____ _____
   _____ _____
2. Yes Snore when sleeping?
3. Yes Breath through mouth?
4. No Have frequent colds?
5. No Have frequent "stuffy nose?"
6. No Have frequent sore throat or tonsillitis?
7. No Have chewing or swallowing difficulty?
8. No Has the patient received medical treatment from allergist or ear, nose and throat specialist?
   If yes: Dates: _____ By Whom: _____
9. Has the patient had: Nasal Surgery: No Tonsils removed: No Adenoids removed: No

DENTAL HISTORY

No Does the patient have pain or clicking in jaw joint?

No Have any teeth been injured due to accidents or blows to the mouth?

No Has the patient received or been requested to receive speech correction?

No The following habits are of interest, List information as it pertains to this patient:

No	Thumb sucking until age _____	No	Teeth Grinding
No	Finger sucking until age _____	No	Tongue thrusting
No	Lip-biting or sucking	No	Other habits

No Has the patient had any unusual dental experiences?

Specify: _____

Date of last dental checkup _____ Were the patient's teeth cleaned? No

ORTHODONTIC HISTORY

• No Has the patient had previous orthodontic consultation? No Previous treatment?

• Date: _____ Dr.: _____

• Why did patient seek this consultation? _____

• What is the primary problem? _____

• What is expected from orthodontic treatment? _____

• Additional comments you wish to make: _____

_____

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of individual completing this form: _____

Relationship to patient: _____ **Today's Date:** _____

Reviewed by Dr.: _____ **Date:** _____

ORTHODONTIC ASSOCIATES

TO BETTER SERVE YOU PLEASE FILL OUT THE FOLLOWING

If you were provided an insurance card, please bring it with you
If you have multiple Insurance coverage please provide information for all.

Patient's name:_____

Patient's date of birth:_____

Subscriber's name:_____

Subscriber's relation to patient:_____

Subscriber's date of birth:_____

Subscriber's social security number:_____

Subscriber's address:_____

Subscriber's phone #:_____

Subscriber's employer:_____

Insurance Company Name:_____

Insurance phone #:_____

Insurance ID#:_____ Group#_____

OFFICE USE ONLY

Office_____ Date_____ Time_____ Rep_____

Rep name:_____

Effective date of policy_____ Referral required?_____

Adult orthodontia? Yes No Age limit?_____

Fee Schedule_____ Deductible_____

Lifetime maximum benefit_____ Waiting period?_____

Maximum used_____ Maximum left_____

Percent_____

Dr. Jeffrey C. Miller
Orthodontic Associates
[Insert Name of Practice]

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

SUBMIT VIA EMAIL

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Dr. Jeffrey C. Miller
Orthodontic Specialties
[Insert Name of Practice]

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer Telephone: (_____) _____–_____ Fax: (_____) _____–_____

Email: Address:

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless we replace it.

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 any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

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. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical 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.

ORTHODONTIC ASSOCIATES

JEFFREY C. MILLER, D.D.S., P.A.*
HEATHER M. ABRAHAMS, D.D.S., M.S.
DAVID C. WILLIAMS, D.D.S.*
KELLY WRAY, D.M.D., M.S.

American Association of Orthodontists TM

* DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Explanation of Orthodontic Fees

Orthodontic fees vary widely depending on the complexity of the case, length of time the patient will be in treatment, and the number of appliances that will be needed to successfully treat the case.

Our "Usual and Customary Fee" covers most all charges associated with the recommended course of treatment. Charges for diagnostic records, appliances (braces, expanders, headgear, etc.), additional diagnostic records, monthly office visits regardless of how long the patient is in braces (providing patient keeps regularly scheduled appointments), orthodontic emergency visits during active treatment, retainers, and follow up care for one year are all included.

Our fees do not include visits to your family dentist or other dental specialists.

If you have one of the HMO/PPO type insurance plans, which our office participates, we follow their fee schedule. Unfortunately, in most cases these fee schedules are "ala carte". **It is the combination of each itemized service that determines the "Total Case Fee" charged. For example, under an HMO/PPO plan, your fee could include additional charges for diagnostic records, upper and lower retainers, follow up care, etc.**

In an effort to avoid additional charges during orthodontic treatment, we make every effort to give a "Total Case Fee" prior to the start of treatment.

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