Boyles Orthodontics

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Personal Information

Patient's Name _____ Preferred Name_____Male____ Female_____

Date of Birth _____ Responsible Party_____

Address_____ City_____ State_____ Zip_____

Telephone: Home _____Cell _____ Email _____

Preferred Method for Appointment Reminders: Text_____ Email _____

General Dentist _____Dentist Location _____

Parent/Patient's Employer_____ Occupation_____

Spouse's Employer _____Occupation_____

Insurance Information

Dental Insurance- Primary Coverage

Employee Name_____ Date of Birth _____

Employer Name _____ Yrs _____ SSN _____

Insurance Company _____ Telephone _____ Group # _____

Dental Insurance- Secondary Coverage

Employee Name_____ Date of Birth _____

Employer Name _____ Yrs _____ SSN _____

Insurance Company _____ Telephone _____ Group # _____

Consent:

I consent to the diagnostic procedures and treatment deemed necessary by the orthodontist. I consent to the orthodontist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the orthodontist or orthodontic group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor. I attest to the accuracy of the information on this page.

Signature of Patient/Responsible Party _____ Date _____

Medical History

Patient's Name _____ Date of birth _____

Pediatrician/Physician _____ Date of last visit _____

Reason for last medical exam _____

Current Medications _____

_____

Allergies _____

Do you have any of the following?

_____ Heart Disease
_____ Rheumatic Fever
_____ Hepatitis
_____ Kidney Disease
_____ Thyroid Disease
_____ Asthma
_____ Anemia
_____ Epilepsy
_____ Blood Disease
_____ High Blood Pressure
_____ Tumors
_____ Liver Disease
_____ Venereal Disease
_____ AIDS
_____ Diabetes
_____ Any surgery

Details of the conditions marked above _____

_____

_____

Are you pregnant? _____ If yes, how many weeks? _____

Do you smoke or use tobacco products? _____

Privacy Notice

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.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects;

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);

- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);

- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;

- Internally to all staff members who have any role in your treatment;

- To other patients and third parties who may see or overhear incidental disclosure about your treatment, scheduling, etc.;

- To your family and close friends involved in your treatment; and or,

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you;

Any other uses or disclosure of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect; and,
- To advise you of our rights to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGEMENT
I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____

Patient Signature Date