A B C

## Patient Information

Date_____ Email_____ Cell Phone_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Home Phone_____ Birthdate_____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

## Responsible Party Information

Name _____
Last First Middle

Residence_____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Cell phone _____

Previous Address (If less than 3 years) _____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security #_____ Birthdate _____ Work Phone _____

## Dental Insurance Information

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

## Emergency Information

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____

Updates (date & initial) _____

## MEDICAL HISTORY

Physician_____ Date of Last Visit _____
Address_____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any major operations? _____
Yes No Have you ever been involved in a serious accident? _____
Circle any of the medical conditions below that you have had or currently have.

| | | | |
|---|---|---|---|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

## DENTAL HISTORY

Dentist_____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours? _____
Please list some hobbies or interests _____
Female Patients only: _____
Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

## BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Mikulencak to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

**Notice of Privacy Practices**

**Effective Date:** March 6, 2013

This Notice of Privacy Practices describes the ways in which medical information about you may be used and disclosed, and how you can obtain access to it. Please review it carefully.

**Understanding Your Health Information** Each time you visit a hospital, physician or other health care provider, a record of your visit is made in order to manage the care you receive. Mik Ortho entities listed on this document understand that the medical information that is recorded about you and your health is personal. The confidentiality of your health information is also protected under both state and federal law.

This Notice of Privacy Practices describes how Mik Ortho may use and disclose your information and the rights that you have regarding your health information. The Notice applies to all of Mik Ortho's locations. It also applies to doctors and staff members at Mik Ortho.

Mik Ortho uses electronic health records and will not use or disclose your health information without written authorization, except as described in this Notice. Use or disclosure pursuant to this Notice may include electronic transfer of your health information.

**Your Health Information Rights** Although your health information is the physical property of the facility or practitioner that compiled it, the information belongs to you, and you have certain rights over that information. You have the right to:

- Request, in writing, a restriction on certain uses and disclosures of your health information. However, agreement with the request is not required by law, such as when it is determined that compliance with the restriction cannot be guaranteed. In addition, you have the right to request, in writing, a restriction on disclosures of health information to a health plan with respect to treatment services for which you have paid out of pocket in full. In this case, we will honor the request. It will be your responsibility to notify any other providers of this restriction.
- Request, by written authorization, to inspect or obtain a copy of your health record as provided by law.
- Request, in writing, that your health record be amended as provided by law, if you feel the health information we have about you is incorrect or incomplete. You will be notified if the request cannot be granted.
- Request that we communicate with you about your health information in a specific way or at a specific location. Reasonable requests will be accommodated.
- Request, in writing, to obtain an accounting of disclosures or a report of who has accessed your health information as provided by law. The access report will only be available after federal regulations become effective.
- Obtain a paper copy of this Notice of Privacy Practices on request.

You may exercise these rights by directing a request to the privacy contact listed on this Notice.

**Our Responsibilities** Mik Ortho has certain responsibilities regarding your health information, including the requirement to:

- Maintain the privacy of your health information.
- Provide you with this Notice that describes the legal duties and privacy practices regarding the information that we maintain about you.
- Abide by the terms of the Notice currently in effect.
- Inform you that Mik Ortho must keep your medical records for a time required by law and then may dispose of them as permitted by law.

Mik Ortho entities reserve the right to change these information privacy policies and practices and to make the changes applicable to any health information that we maintain. If changes are made, the revised Notice of Privacy Practices will be made available at each Mik Ortho location, posted on each entity website, and will be supplied when requested.

**Uses and Disclosures of Health Information without Authorization** When you obtain services from any Mik Ortho location, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment and to support the operations of the entity and other involved providers. The following categories describe ways that Mik Ortho use or disclose your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

***Your health information will be used for treatment.*** Example: Disclosures of medical information about you may be made to referring doctors, staff members, technicians, or others who are involved in taking care of you at a Mik Ortho location. This information may be disclosed to other physicians who are treating you or to other health care facilities involved in your care. Information may be shared with pharmacies, laboratories or radiology centers for the coordination of different treatments.

***Your health information will be used for payment.*** Example: Health information about you may be disclosed so that services provided to you may be billed to an insurance company or a third party. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment.

***Your health information will be used for health care operations***. Example: The information in your health record may be used to evaluate and improve the quality of the care and services we provide.

***Business Associates*** There are some services that we provide through contracts with third party business associates. Examples include Vanco and other Merchant Services. To protect your health information, Mik Ortho entities require these business associates to appropriately protect your information.

**Disclosures Requiring Verbal Agreement** Unless you give notice of an objection, and in accordance with your agreement, medical information

may be released to a family member or other person who is involved in your medical care or who helps pay for your care. Information about you may be disclosed to notify a family member, legally authorized representative or other person responsible for your care about your location and general condition. This may include disclosures of information about you to an organization assisting in a disaster relief effort, such as the American Red Cross, so that your family can be notified about your condition. You will be given an opportunity to agree or object to these disclosures except as due to your incapacity or in emergency circumstances.

**Disclosures Required by Law or otherwise Allowed without Authorization or Notification** The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:

- When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or for law enforcement. Examples would be reporting gunshot wounds or child abuse, or responding to court orders.
- For public health purposes, such as reporting information about births, deaths, and various diseases, or disclosures to the FDA regarding adverse events related to food, medications or devices.
- For health oversight activities, such as audits, inspections or licensure investigations.
- To organ procurement organizations for the purpose of tissue donation and transplant.
- For research purposes, when the research has been approved by an institutional review board that has reviewed the research proposal and established guidelines to provide for the privacy of your health information; or the disclosure is that of a limited data set, where personal identifiers have been removed.
- To coroners and funeral directors for the purpose of identification, the determination of the cause of death, or to perform their duties as authorized by law.
- To avoid a serious threat to the health or safety of a person or the public.
- For specific government functions, such as protection of the president of the United States.
- For workers' compensation purposes.
- To military command authorities as required for members of the armed forces.
- To authorized federal officials for national security and intelligence activities as authorized by law.
- To correctional institutions or law enforcement officials concerning the health information of inmates, as authorized by law.

***Other Uses or Disclosures*** Other uses or disclosures of your health information that may be made include:

- Contacting you to provide appointment reminders for treatment or medical care, as well as to recommend treatment alternatives.
- Notifying you of health-related benefits and services that may be of interest to you.
- Contacting you about disease management programs, wellness programs, or other community-based initiatives or activities in which Mik Ortho participates.
- If Mik Ortho is paid by any third party to provide communications to you because you are a patient, you will be informed that Mik Ortho is being paid. You have the right to opt out of receiving such communications.
- Using your health information for the purposes of fundraising for a Mik Ortho. You will have the opportunity to opt out of any future communications. Contact the privacy officer on this notice for instructions on opting out.

***Breach Notification*** In certain instances, you have the right to be notified in the event that we, or one of our business associates, discover an inappropriate use or disclosure of your health information. Notice of any such use or disclosure will be made as required by state and federal law.

***Required Uses and Disclosures*** Under the law we must make disclosures when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy law.

**Uses and Disclosures Requiring Authorization** Any other uses or disclosures of your health information not addressed in this notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time. Specific examples of uses or disclosures requiring authorization include: use of psychotherapy notes, marketing activities, and some types of sale of your health information.

**Privacy Complaints** You have the right to file a complaint if you believe your privacy rights have been violated. The complaint may be addressed to the privacy contact listed in this notice, or to the secretary of the Department of Health and Human Services. There will be no retaliation for registering a complaint.

**Privacy Contact** Address any questions about this notice or how to exercise your privacy rights to the applicable privacy officer contact listed below.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of this office's Notice of Privacy Practices for:

Patient(s)_____Signature of Patient/Parent/Guardian and Date:_____