



Welcome to our practice!

Patient's Name: _____ Preferred Name: _____
 Today's Date: ____ / ____ / ____ Birthdate: ____ / ____ / ____ Age: ____ Sex: Male / Female
 Home Address: _____ City, State and Zip Code: _____
 How long at this address? ____ Mailing address same as above? Y / N If no, please specify: _____
 Social Security No: _____ Email Address: _____
 Home Phone: (____) _____ Cell Phone: (____) _____ Work: (____) _____
 Brothers/Sisters or Sons/Daughters (names & ages): _____
 Whom may we thank for referring you to our office? _____

Responsible Party Information

Name: _____ Relationship to Patient: _____
 Address: _____ City, State and Zip Code: _____
 Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____
 Birthdate: ____ / ____ / ____ Social Security No: _____ Driver's Lic. No.: _____
 Employed By: _____ For how long? ____ Occupation: _____
 Interests: _____ Marital Status: Single / Married / Separated / Widowed / Divorced
 Does the primary responsible party have orthodontic insurance? Yes / No **If yes, please complete insurance portion**

.....
 Spouse's Name/Secondary Responsible: _____ Relationship to Patient: _____
 Address: _____ City, State and Zip Code: _____
 Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____
 Birthdate: ____ / ____ / ____ Social Security No: _____ Driver's Lic. No.: _____
 Employed By: _____ For how long? ____ Occupation: _____
 Does the secondary responsible party have orthodontic insurance? Yes / No *If yes, please complete insurance portion*

Dental Insurance Information

Insured's Name: _____ Social Security: _____
 Insurance Company: _____ Group No.: _____
 Insurance Co. Address: _____ Phone No.: (____) _____
 Insured's Employer: _____ Employer Address, City & Zip: _____
 Is this the primary insurance for the patient? Yes / No **If there is dual coverage, please complete secondary info**

.....
 SECONDARY Insured's Name: _____ Social Security: _____
 Insurance Company: _____ Group No.: _____
 Insurance Co. Address: _____ Phone No.: (____) _____
 Insured's Employer: _____ Employer Address, City & Zip: _____

Emergency Contact

Name of nearest relative not living with you: _____ Phone: (____) _____
 Address, City, State and Zip Code: _____ Relationship to Patient: _____

Medical History

Physician Name: _____ Date of Last Visit: _____

Address: _____ Phone No.: (____) _____

Please check Yes or No for the questions below. If yes, please fill in details:

- | | | |
|---------------------------|--------------------------|---|
| <input type="radio"/> Yes | <input type="radio"/> No | Are you taking any medications? _____ |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you allergic to any medications? _____ |
| <input type="radio"/> Yes | <input type="radio"/> No | Do you have a history of a major illness? _____ |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you had any operations? _____ |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever been involved in a serious accident? _____ |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever smoked or chewed tobacco? _____ |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you seen a physician in the last 12 months? If yes, why? _____ |

For female patients:

- | | | |
|---------------------------|--------------------------|---------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No | Are you pregnant? |
| <input type="radio"/> Yes | <input type="radio"/> No | Has menstruation started? |

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/Chemo
Asthma/Hay Fever	Gastrointestinal Problems	HIV/AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Dental History

General Dentist: _____ Date of Last Visit: _____ Phone: (____) _____

****Please tell us what concerns you most about your teeth:** _____

- | | | |
|---------------------------|--------------------------|---|
| <input type="radio"/> Yes | <input type="radio"/> No | Are you presently in any dental pain? |
| <input type="radio"/> Yes | <input type="radio"/> No | Have your wisdom teeth been removed? |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever lost or chipped any teeth? |
| <input type="radio"/> Yes | <input type="radio"/> No | Have there been any injuries to face, mouth or teeth? |
| <input type="radio"/> Yes | <input type="radio"/> No | Is any part of your mouth sensitive to temperature? If so, where? |
| <input type="radio"/> Yes | <input type="radio"/> No | Is any part of your mouth sensitive to pressure? If so, where? |
| <input type="radio"/> Yes | <input type="radio"/> No | Do your gums bleed when you brush? |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever experienced any unfavorable reaction to dentistry? If so, what? |
| <input type="radio"/> Yes | <input type="radio"/> No | Do you have any type of thumb or tongue habit? |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you a mouth breather? |
| <input type="radio"/> Yes | <input type="radio"/> No | Do your teeth or jaws ever feel uncomfortable when you wake in morning? |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you aware of your jaw clicking or popping? |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you aware of clenching your teeth during the day? |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever been told that you grind your teeth? |
| <input type="radio"/> Yes | <input type="radio"/> No | Do you have "tension" headaches? |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever experienced chronic ringing in your ears? |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever seen an orthodontist? If yes, who and when? _____ |
| | | What is your attitude toward receiving orthodontic treatment? _____ |
| <input type="radio"/> Yes | <input type="radio"/> No | Has anyone in your family received orthodontic treatment? If so, who? _____ |
| | | How did they feel about the results? _____ |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you aware that some appointments will be during work/school hours? |

Benefits of Orthodontics: Aesthetics, Health and Function. It is a service that provides improvement in the appearance of 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 can 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 purposes. I have truthfully answered all of the above questions and agree to inform Dr. Freeman's office of any changes in my medical or dental history. In addition, I authorize Dr. David C. Freeman to perform a complete orthodontic evaluation.

Signature: _____ Date: _____



Freeman Orthodontics

DAVID C. FREEMAN, DDS, MS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law 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 09/07/09, and will remain in effect until 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 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 use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations 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 other 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 communications without your written authorization.



Freeman Orthodontics

DAVID C. FREEMAN, DDS, MS

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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, 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 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 copies, we will charge you \$0.10 for each page, \$25 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. 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 to 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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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.

Contact Officer: Katherine Valdez Telephone: (559)325-3300 Fax: (559)326-7682



Acknowledgement of Receipt of "Notice of Privacy Practices"

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

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

Please Print Name (and name of patient if patient is a minor)

Signature

Date

FOR OFFICE USE ONLY

DATE: _____

INITIALS: _____

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 _____