Dempsey Orthodontics

1. PATIENT INFORMATION

Patient First Name _____

Patient's Middle Name or Initial _____

Patient Last Name _____

Patient's Date of Birth _____

Patient's Gender _____

Mailing Address, City, State, and Zip Code

_____

Cell Phone _____Cell Carrier:_____

Email Address _____

If a patient is a minor, please list parent or guardian name _____

Does the patient have siblings? If yes, please list names and ages

_____

Other family members seen by us _____

Is the patient currently attending school? If so, where? _____

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

Is there anything you would like to privately discuss with Dr Dempsey? If so, what?

_____

_____

_____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party _____

Marital Status _____

DENTAL INSURANCE INFORMATION

Insured's Name _____

Insured's Social Security Number (XXX-XX-XXXX)_____

Insured's Date of Birth _____

Name of Dental Insurance Company _____

Insured's Employer _____

Group # _____

Insured's ID # _____

Insurance Company Address, City, State, Zip Code (P.O. Box if applicable)

_____

_____

Insurance Company's Phone Number _____

IF YOU HAVE DUAL DENTAL INSURANCE COVERAGE, PLEASE COMPLETE

Insured's Name _____

Insured's Social Security Number (XXX-XX-XXXX)_____

Insured's Date of Birth _____

Name of Dental Insurance Company _____

Insured's Employer _____

Group # _____

Insured's ID # _____

Insurance Company Address, City, State, Zip Code (P.O. Box if applicable)

_____

_____

Insurance Company's Phone Number _____

2. EMERGENCY INFORMATION

In the event of an emergency, who would you like for us to contact?_____

Relationship to Patient _____

Emergency Contact's Cell Phone _____

Emergency Contact's Home Phone _____

Emergency Contact's Work Phone _____

3. MEDICAL HISTORY

Please complete this section to the best of your knowledge. It's important for us to be aware of any health issues that may affect the treatment you receive from our office. This is kept strictly confidential.

Physician's Name _____

Date of Last Visit _____

Physician's Address, City, State, and Zip Code
_____

Physician's Phone Number_____

Is the patient taking any medications? If yes, please list below.
_____

_____

Has the patient had any major illnesses? If yes, please list below.
_____

_____

Has the patient had any major operations? If yes, please list below with corresponding dates.
_____

_____

Has the patient been involved in any serious accidents? If so, please briefly describe, along with the date of the occurrence.
_____

_____

_____

Please review the following conditions and list any the patient has or has had below.

Heart Murmur	Heart Attack	Heart Surgery
Heart Disease	Pacemaker	Congenital Heart Defect
Artificial Heart Valve(s)	Mitral Valve Prolapse	High Blood Pressure
Low Blood Pressure	Angina	Blood Disease
Cancer	Tumor/Growth(s)	Chemotherapy/Radiation
Lung Disease	Tuberculosis	Anemia
Shingles	GI Problems	Kidney Problems
Emphysema	Seizures/Epilepsy	Chest Pains
Respiratory Problems	Diabetes	Hypoglycemia
Liver Problems	Hepatitis	Arthritis
Rheumatic Fever	Scarlet Fever	Cold/Fever Blisters
Alcohol Abuse	Drug Abuse	Nervousness
Eating Disorder	Jaw Problems/TMD	Sleep Apnea
Allergies	Asthma	Venereal Disease
Cosmetic Surgery	Dizziness/Fainting	

Please list any of the above the patient has or has had.

_____

_____

_____

Are there any other medical conditions not listed that you feel we should be aware of?

_____

_____

_____

Does the patient have allergies to any of the following? If yes, which ones?

Latex, Penicillin, Aspirin, Dental Anesthetics, Nickel, Any other metals, Foods

_____

_____

_____

4. DENTAL HISTORY

Name of General Dentist _____

Date of Last Visit _____

Phone Number of General Dentist _____

What concerns you/the patient most about his/her teeth?

_____

Is the patient currently having any dental pain? If so, please explain.

_____

_____

Has the patient had any bad reaction(s) to dentistry? If yes, please explain.

_____

_____

Please review the following conditions and list any the patient has or has had below.

Missing permanent teeth	Chipped/broken teeth	Tooth sensitivity
Injuries to the face, mouth, teeth	Thumb/tongue habit	Mouth breathing
Teeth sensitivity to bite pressure	Teeth grinding	Tension headaches
Clicking/popping in jaw joint	Jaw discomfort	Ringing in ears
Red/swollen/bleeding gums	Jaw pain	

Please list any of the above that the patient has or has had. Please list any other dental condition that the patient has or has had that is not listed above.

_____

_____

_____

Has the patient ever seen an orthodontist? If yes, when?

_____

Please print your full name and e-sign. _____

X _____ Ip Address

Dempsey Orthodontics Notice of Privacy Practices/ (NPP)/ HIPAA Compliance

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.

We are required by law to maintain the privacy of protected health information (PHI), to provide individuals with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 8/1/2017 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, and to make new provisions effective for all PHI that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post it clearly and prominently in our office, and we will provide copies upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we provided a description and example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use and disclose your PHI to a physician or other healthcare provider providing treatment to you or to providers in consultation with your treatment.

Payment: We may use or disclose your PHI to obtain payment for services we provide to you. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, and insurance company, or another third party.

Educational Instruction: We may use or disclose your PHI in the diagnosis and treatment of your case for the instruction and advancement of knowledge for health care professionals and in university studies.

Healthcare Operations: We may use or disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in your care or Payment for your care: We may disclose your PHI to your family, friends, or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that representative the same way we would treat you with respect to your health information.

Disaster Relief: We may use or disclose your PHI to assist in disaster relief efforts.

Required by Law: We may use or disclose your PHI when we are required to do so by law.

Public Health Activities: We may disclose your PHI for public health activities, including disclosures to: prevent or control disease, injury, or disability; report reactions to medications or problems with products or devices; notify a person of a recall, repair, or replacement of products or devices; notify a person who may have been exposed to a disease or condition; or report the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security: We may disclose to military authorities the PHI 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 the PHI of an inmate or patient.

Secretary of HHS: We will disclose your PHI to the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law, including audits, investigators,

inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable state law to enable them to carry out their duties.

Fundraising: We may contact you to provide you with information about our sponsored activities as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (text, email, etc). You may choose to opt out.

Other Used and Disclosures of PHI: Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization provided for in this NPP before using or disclosing your PHI for purposes other than those provided for in this NPP (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action and reliance on the authorization.

Your Health Information Rights:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have a right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your PHI in accordance of applicable laws and regulations. To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction: You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include 1) what information you want to limit, 2) whether you want to limit our use, disclosure, or both, and 3) to whom you want the limits to apply. **We are not required to agree to your request except in a case where the disclosure is to a health plan for purposes of carrying our payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communications: You have the right to request that we communicate with you about your PHI 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 about how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests; however, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured PHI as required by law.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this NPP electronically on our website or by e-mail.

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 if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI 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. 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. HSS.

Our Privacy Official: Dr. Meredith K. Dempsey

Telephone: (770) 271-0833, Fax: (770) 614-6460, Address: 4330 South Lee Street, Building 500, Buford GA 30518, email: info@dempseyortho.net

Dempsey Orthodontics Acknowledgement of Receipt of Notice of Privacy Practices

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

Print Name: _____

Date: _____

For Office Use Only

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

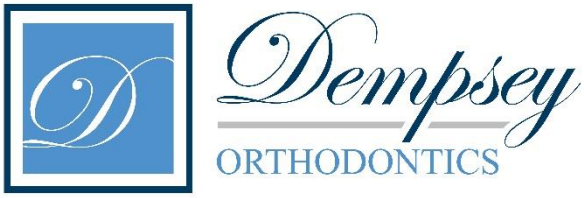
□ Other (Please specify)

DEMPSEY ORTHODONTICS, LLC COMMUNICATION DISCLOSURE

Communication Disclosure Text messages and emails can be used to communicate in a manner that is compliant with HIPAA. However, it is your responsibility to review what information can be communicated via text or email, specifically sensitive information. Text messages sent from our office are transmitted via traditional SMS text message methods. Traditional SMS text messages are considered an insecure mode of communication, as texts are not encrypted in transit, and there are limited controls over the message after it is sent.

Full Name:_____

DATE:_____



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Last Name_____ Patient's First Name_____

Patient's Date of birth_____

Patient's
address:_____

I, _____,hereby authorize Dempsey Orthodontics to release information, (name of patient OR parent/legal guardian if patient is under 18 years of age)

As indicated below, to the following individual(s):

Name	Relationship to patient	phone number	Any	Clinical	Financial
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____

I authorize Dempsey Orthodontics to contact the individual(s) listed above to convey information as listed above regarding the "patient" in the event that I am unable to be reached by Dempsey Orthodontics or if I am not present for the appointment. I understand that I may revoke/cancel this authorization by notifying Dempsey Orthodontics, in writing, of my intent to revoke authorization, or change the name(s) of those listed to whom the information is released

Under no circumstances, is any information, clinical, financial, or any other information to be shared with the following individuals:

_____ _____

Signature of patient or parent/legal Guardian if patient is under 18 yrs old Date

_____

Printed Name