Johnson ORTHODONTICS

New Patient Adult Registration

Patient Information

Full Name _____ Nickname _____ ☐Male ☐Female

Address _____
Street City State Zip

D.O.B. _____/_____/_____ SSN _____ Email _____

Would you like to be added to our email list to receive information about upcoming events and promotions? ☐Yes ☐No

Phone #s _____
Home Work Cell

Employer _____ Occupation _____ Years Employed _____

Hobbies, Activities _____

Dentist _____ Date of Last Visit _____

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

Responsible Party Information (if different from patient)

Full Name _____ Relationship to Patient _____

D.O.B. _____/_____/_____ SSN _____ Email _____

Address _____
Street City State Zip

Phone _____
Home Work Cell

Employer _____ Occupation _____ Years Employed _____

Insurance Information

*Please present your insurance card at time of appointment so that we may keep a copy on file.

Insurance Company _____ Phone # for Insurance Co _____

Policy Holder's Name _____ SSN _____ D.O.B. ____/____/____

Contract # _____ Group/Policy # _____

Policy Holder's Employer _____

Emergency Contact

Name _____ Relationship to patient _____

Phone #_____

Appointment Reminders

How would you like to recieve appointment reminders? *Please select at least one option.*

☐ Text Message ☐ Email ☐ Phone call / Voicemail

_____ _____ _____
phone # email address phone #

_____
cell phone service provider

Dental History

What would you like orthodontic treatment to accomplish? _____

_____

Has another orthodontist been consulted or previous orthodontic treatment been provided? ☐ Yes ☐ No

If yes, what work has been completed and by whom? _____

Please check all symptoms that you have had and/or currently have

☐ Periodontal/gum disease or treatment
☐ Pain or discomfort in the jaw joint
☐ Clenching or grinding teeth
☐ Gums bleed when brushing
☐ Thumb/finger sucking habit
☐ Speech problems
☐ Serious trauma/injury to teeth, face, jaw or head
☐ Sensitivity to temperature or pressure
☐ Adverse reaction during a medical/dental procedure

What is your attitude toward receiving orthodontic treatment? _____

Please list any family history of orthodontic treatment or jaw problems _____

_____

Medical History

Are you currently under the care of a physician?... ☐ Yes ☐ No If yes, name of physician _____

Have you had your tonsils/adenoids removed?..... ☐ Yes ☐ No

Have you ever taken a bisphosphonate medication (used to treat bone disorders)?..... ☐ Yes ☐ No

Ladies, are you pregnant or think you may be pregnant?..... ☐ Yes ☐ No

Have you ever been required to take antibiotics (pre-medication) before a routine dental visit?..... ☐ Yes ☐ No

Have you ever used tobacco products?..... ☐ Yes ☐ No If yes, what type & how often? _____

Are you allergic to any medications?..... ☐ Yes ☐ No If yes, what medication(s)? _____

Please list any allergies to latex, nickel, metal, and/or plastic _____

Please list all other known allergies _____

Please list all medications (prescription and over-the-counter) _____

_____

Please list all hospitalizations/operations _____

Please check all of the conditions that you have had and/or currently have

☐ Asthma	☐ Kidney Problems	☐ Hepatitis	☐ Osteoporosis	☐ Joint Disease/Arthritis
☐ HIV+ / AIDS	☐ Epilepsy	☐ Heart Murmur	☐ Tumor/Cancer	☐ Diabetes
☐ Heart Problems	☐ Bleeding Disorder	☐ Dizziness	☐ High Blood Pressure	☐ Endocrine Problems
☐ Tuberculosis	☐ Rheumatic Fever	☐ Herpes	☐ Low Blood Pressure	☐ Gastrointestinal Disorder

Please list any other medical condition(s) or considerations we should be aware of: _____

_____

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my/patient's medical status. The doctor and/or his staff will not be held responsible for any errors or omissions I have made on this form. I authorize the release of any information necessary to process insurance claims. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for any amount not covered by insurance. I authorize Dr. Johnson and his staff to communicate with other doctors who may be involved in my healthcare.

_____ _____

Signature (parent/guardian signature if under 18) Date

Johnson ORTHODONTICS

Notice of Patient 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 August 29, 2012, 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.

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

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, text 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 $0.50 for each page, $30.00 per hour of staff time to locate and copy your health information, and postage if you want 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.

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. 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.

FOR MORE INFORMATION ABOUT HIPAA PLEASE CONTACT

Nathan Johnson, DMD, MS
2124 Cecil Ashburn Drive
Suite 170
Huntsville, AL 35802

The Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practices.
Please Print Name

_____ _____
Signature Date

Johnson ORTHODONTICS

Photo Release

I, _____, do hereby relinquish any and all rights to
print patient's name
photographs, portraits, transparencies, negatives, prints, Polaroids or other photographic reproductions captured with still, motion-picture, video, digital or other cameras for use by Johnson Orthodontics.

Patient's Name:

Address:

City, State, Zip:

Phone#:

_____ _____
Patient's signature or parent/legal guardian signature if patient is under 18 Date