

Hodges Orthodontics

101 N. Davis Street
Sulphur Springs, TX 75482
903-885-2800

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- Your protected health information (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine results of cleanings, surgery, etc.);
- To third party payers of spouses (i.e., Insurance Companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.);
- To certify licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- To other patients and third parties who may see or overhear incidental disclosures 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 disclosures 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 your 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 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 right to change the terms of the Privacy Notice and to make 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 revised 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 our Privacy Contact Person or direct questions to this person at our office address. Thank you.

Parent/Guardian Acknowledgment

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

Patient Printed Name

Signature of Patient/Parent or Guardian

Date

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CHILD PATIENT INFORMATION

Today's Date: _____
Name: _____ Prefers to be called: _____ Sex: _____
Age: _____ Date of Birth: _____ Phone Number: _____
Patient's Interests: _____
Patient resides with : Mother Father Both Other: _____
Address: _____ City: _____ State: _____ Zip: _____
Patient's Dentist: _____ School: _____ Grade: _____
Describe your child's orthodontic problem: _____
Has any member of the family had orthodontic treatment? If so, by whom: _____
Please list names of other family members treated in our office _____
Whom may we thank for referring you to our office? _____
Who is accompanying the patient today? _____

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status: Married Separated Divorced Widowed

FATHER

MOTHER

Name:	_____	_____
Date of Birth:	_____	_____
Address: (if different than above)	_____	_____
Phone: (if different than above)	_____	_____
E-mail Address:	_____	_____
Employer's Name:	_____	_____
Occupation:	_____	_____
Person responsible for account:	_____	_____

If other than parent:

Name: _____ Address: _____ Phone: _____

In case of an emergency, please provide name, address, and phone number of your nearest relative:

Name: _____ Address: _____ Phone: _____

INSURANCE INFORMATION

If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of Policyholder: _____

Date of Birth: _____ Social Security #: _____ - _____ - _____

Insurance carrier company: _____

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ADULT PATIENT INFORMATION

Today's Date: _____
Name: _____ Prefer to be called: _____ Sex: _____
Age: _____ Birthdate: _____ Social Security #: _____ - _____ - _____ Married Single Divorced Widowed
Spouse's Name: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Email Address: _____
Occupation: _____ Employer: _____
Dentist: _____
Do you know a patient currently in our practice? If so, whom: _____
Has any member of the family had orthodontic treatment? If so, by whom?: _____
Please list names of other family members treated in our office: _____
Who noticed your orthodontic problem? Self Dentist Other _____
Describe your orthodontic problem in your own words: _____
What concerns you most about orthodontic treatment?
Appearance in appliances Cost Length of time Discomfort Results Other _____
If you could change anything about your smile, what would it be? _____
Whom may we thank for referring you to our office? _____

ACCOUNT INFORMATION

Person responsible for account: _____
If other than self:
Name: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
In case of emergency, please provide name, address and phone number of your nearest relative:
Name: _____ Address: _____
Phone #: _____

INSURANCE INFORMATION

Name of insured: _____ Date of Birth: _____
Social Security #: _____ - _____ - _____ Insurance carrier/company: _____

MEDICAL HISTORY

Your answer to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.

Physician's Name: _____	Address: _____	Phone: _____
Have you experienced any health problems?	No Yes	Explain: _____
Any major change in your health recently?	No Yes	Explain: _____
Are you currently under a physician's care?	No Yes	Explain: _____
Are you allergic to any medications?	No Yes	Explain: _____
Have you received a blood transfusion?	No Yes	Explain: _____
Have your tonsils or adenoids been removed?	No Yes	Explain: _____
Are you taking any medications?	No Yes	Explain: _____