OLYMPIC ORTHODONTICS

Frederick L. Johnston D.D.S.

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PATIENT REGISTRATION HISTORY - CHILD

NAME _____ ☐ MALE ☐ FEMALE BIRTH DATE ____/____/____
First Middle Last

HOME ADDRESS _____
Street City State Zip

HOME PHONE _____ E-MAIL _____ CELL _____

MOTHER'S NAME _____ EMPLOYER _____ D.O.B. _____ PH# _____

FATHER'S NAME _____ EMPLOYER _____ D.O.B. _____ PH# _____

MOTHER'S SOCIAL SECURITY # ____-____-____ FATHER'S SOCIAL SECURITY # ____-____-____

PATIENT LIVES WITH ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER **REFERRED BY?** _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE _____ DATE OF LAST VISIT ____/____/____

PLEASE CHECK YES OR NO TO THE FOLLOWING:

YES	NO	
☐	☐	Has patient had a physical exam in the last year?
☐	☐	Is patient presently under a physician's care?
☐	☐	Has patient ever been hospitalized?
☐	☐	Is patient taking any pills, medication or drugs?
☐	☐	Has patient ever had major surgery?
☐	☐	Has patient had any reactions to any medications?
☐	☐	Has patient had his/her tonsils and/or adenoids removed?
☐	☐	Does patient experience fainting or dizzy spells?
☐	☐	Does patient have too high or too low blood pressure?

HAS PATIENT BEEN DIAGNOSED OR TREATED FOR:

YES	NO		YES	NO	
☐	☐	Heart problems	☐	☐	Hepatitis
☐	☐	Kidney problems	☐	☐	Allergies
☐	☐	Rheumatic fever	☐	☐	Diabetes
☐	☐	Lung problems	☐	☐	Malignancies
☐	☐	Liver problems	☐	☐	Anemia
☐	☐	Endocrine problems	☐	☐	Arthritis
☐	☐	Prolonged bleeding	☐	☐	Bone
☐	☐	Tuberculosis	☐	☐	Asthma
☐	☐	Herpes	☐	☐	AIDS

PLEASE CHECK IF PATIENT IS ALLERGIC TO THE FOLLOWING:

☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Sulfa ☐ Latex ☐ Metals ☐ Other _____

Are there any other medical problems I should be aware of? _____

DENTAL HISTORY

DENTIST'S NAME _____ PHONE _____ DATE OF LAST CLEANING ____/____/____

YES	NO	
☐	☐	Has patient ever had orthodontic consultations or treatment?
☐	☐	Has patient been informed of any missing teeth?
☐	☐	Have any permanent teeth been removed by extraction?
☐	☐	Has a family member had orthodontic treatment?
		Who? _____
☐	☐	Does patient breathe predominately through his/her mouth?
☐	☐	Does patient have any speech problems?
☐	☐	Does patient now suck his/her thumb or finger?

YES	NO	
☐	☐	Does patient grind or clench his/her teeth?
☐	☐	Does patient have pain or clicking of the jaw joint?
☐	☐	Has patient ever had any teeth injured due to an accident?
☐	☐	Has patient ever had pains in the face ?
☐	☐	Has patient ever had a severe jaw or head injury?
☐	☐	Does patient want his/her teeth straightened?
☐	☐	Does patient's gums bleed when brushing or flossing?

Are there any other dental/orthodontic problems I should be aware of? _____

PARENT/GUARDIAN SIGNATURE _____ DATE ____/____/____

DR SIGNATURE _____ DATE ____/____/____

HEALTH HISTORY UPDATED _____ HEALTH HISTORY UPDATED _____

HEALTH HISTORY UPDATED _____ HEALTH HISTORY UPDATED _____

HEALTH HISTORY UPDATED _____ HEALTH HISTORY UPDATED _____

HEALTH HISTORY UPDATED _____ HEALTH HISTORY UPDATED _____

WELCOME TO OUR OFFICE!!

We are really happy you will be visiting our office and we promise to give you the very best orthodontic care possible. We also would like for you to ENJOY the time you spend in our office! To help us get to know you a little better, would you please answer the questions we have written below.

Your Name is _____

The name or nickname I like to be called is _____

My favorite kind of music is _____

My favorite singer or music group is _____

The things I like best about school is _____

In my spare time, I really like to _____

The sports I enjoy are _____

Do you have any pets? _____ What kind? _____

I think having braces would be _____

Do you have any friends who come to our office? _____

Their names are_____

MOST IMPORTANT QUESTION

Is there something special about yourself that you would like us to know?

_____

Thank you for helping us to get to know you a little better! We are looking forward to meeting you in person!!!

Dr. J, , Denise, Lizette, Maggie, Tiffany, Celina, Rosa, Janelle and Ally

Form 14-208F1

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}

For Office Use Only

We attempted to obtain written Acknowledgement of Receipt of 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)

_____

_____

_____

OLYMPIC ORTHODONTICS
FREDERICK L. JOHNSTON, D.D.S

_____ _____
Employee Name Office Name

_____ _____
Employee Signature Date

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 and/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 correction institutions or law enforcement officials having lawful custody of protected health information on 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, email, 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 photocopy. We will use the format you request unless we cannot PRACTICALLY 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 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 health care 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-base fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions use or disclosure of you 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 an alternative location. You must make your request that we communicate with you about your health information by alternative means or to alternative locations 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 on request.

Amendment: You have the right to request that we amend you 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have question or concerns, please contact us as follows:

Compliance officer
InterDent Service Corporation
222 N. Sepulveda Blvd., Suite 740
compliance@interdent.com

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we make 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 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 complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of you 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

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 April 14, 2003 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 practice, 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 dentist 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 qualification 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 our family and friends: We must disclose you health information to you, as described in the Patient Rights section to this Notice. We may disclose your health information to a family member, friend or other person that is necessary to help with your healthcare or with payment for you 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, or 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 you incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the persons involvement in your healthcare. We 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 x-rays or other similar forms of health information.

Marketing Health-Realated services: We will not use your health for marketing communication without your written authorization.

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