NOTICE OF PRIVACY PRACTICES

STEVE CHAPMAN ORTHODONTICS

PRIVACY AND SECURITY

Our Practice's privacy and security practices are derived from the Department of Health and Human Services regulations, which were implemented in 2003 and include the omnibus updates that went into effect as of September 18, 2013. We are required to keep your personal and health information secure and confidential at all times. A copy of our privacy practices is available at our reception desk.

YOUR PERSONAL AND HEALTH INFORMATION WILL NEVER BE USED NOR DISCLOSED EXCEPT FOR THE PROVISIONS LISTED IN THIS NOTICE, EXEPT WITH YOUR WRITTEN PERMISSION.

You may request that we not use nor disclose some or all of your information as described in this notice. This request must be in writing and we will promptly advise you if we are able to fulfill your request.

We are allowed to use or disclose you personal information in normal and customary manners such as with other Healthcare Providers involved with your treatment. We may also use and disclose your information for payment services with insurance companies to include but not limited to reports on your treatment and progress.

We may use your information with our Business Associates such as Labs and billing companies, all of which we have a written contract to protect and keep your private information secure and confidential.

We may contact you or your assigned designee about treatment follow up, account information, newsletters or other information by phone, text, email or mail. If you do not answer the phone, we may leave a message for you on your answering machine, voicemail or whomever answers the phone number you provide us with. In an emergency, we may disclose your health information with your family, a designee or other persons responsible for your care. We will release some or all of your personal and health information when required by law.

PATIENT RIGHTS

You have the right to know of any use or disclosure of your information other than the normal and customary, should they occur.

You have the right to receive a copy of this notice and it is always available at our reception desk.

You have the right to review and obtain a copy of your health information, with few exceptions. If you would like a copy of this information, please submit a request in in writing for the specific information you would like. If you prefer a digital copy and copy and it is available, we will try to accommodate your request. We may charge a reasonable fee to cover the cost.

You have the right to have a copy of your records transferred to another practice. Notify us in writing of where you would like this information sent.

You have the right to request, in writing, an amendment or change to your health information or for a statement to be added to your file. We may or may not be able to make a change to your request but will include your statement in your records. If we agree to an amendment or change, we will not remove nor alter earlier documents but will add the new information.

You have the right to know if our privacy and security measures or systems are ever breached and be notified.

If we change any of the details of this Notice, we will post the new Notice prominently in our practice location and on our website with a copy available upon request.

WELCOME

We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation

Patient Information - Child or Teen

Patient's Name ______________________ Age ______ Birth Date ______________
First Middle Last

Nickname (if preferred) ______________ Male Female Patient's Home Phone ______________

Patient's Home Address ______________ City, State, ZIP ______________
Street

Email ______________

Who is filling in this form? Name ______________
First Middle Last

Relationship ______________ Do you have legal custody? YES NO

Patient's General Dentist ______________ How did you find out about our office? ______________

Have we treated another member of your family? YES NO If YES, Name ______________
First Middle Last

What are the main concerns that you would like orthodontics to accomplish? ______________

Has your child visited an orthodontist before? YES NO If YES, for what reason? ______________

Parents Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

Father

Father Step Father Guardian Name ______________
First Middle Last

Address (if different than child's) ______________ Birthdate ______________

Email: ______________

Home Phone ______________ Work Phone ______________ Cell Phone ______________ SS # ______________

Employer ______________ Employer's Address ______________

If you have insurance coverage for the child, please fill out.

Insurance Company Name ______________ Group or Plan # ______________

Insurance Company Phone # ______________ Insurance Company Address ______________

Mother

Mother Step Mother Guardian Name ______________
First Middle Last

Address (if different than child's) ______________ Birthdate ______________

Email ______________

Home Phone ______________ Work Phone ______________ Cell Phone ______________ SS # ______________

Employer ______________ Employer's Address ______________

If you have insurance coverage for the child, please fill out.

Insurance Company Name ______________ Group or Plan # ______________

Insurance Company Phone # ______________ Insurance Company Address ______________

Dental and Medical History

Is the child currently under the care of a physician? YES NO If YES, for what reason? ______________________

Child's Physician ____ Phone # ______________________

History of major illness? YES NO If YES, please describe ____

Any sensitivities or allergies? YES NO If YES, please list ____

Currently taking any medications? YES NO If YES, please list ______________ Amount/Dose ______________

Has Puberty Begun? YES NO

Has menstruation (period) begun? YES NO NO APPLICABLE

Has the child been treated for any of the following?

Arthritis	Blood Disorder	Diabetes	Heart Condition	Tuberculosis
Asthma	Cancer	Epilepsy	Nervous Disorder	

Does the child require antibiotics before dental treatment? YES NO If YES, explain ______________________

Have the adenoids or tonsils been removed? YES NO

Have you been informed of any missing or extra permanent teeth? YES NO

Have there been injuries to the child's face, mouth or chin? YES NO

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD) YES NO

Does/Did the child have any of the following habits?

Grinding Teeth	Finger/Thumb Sucking	Prolonged Bottle/Pacifier
Mouth Breather	Speech Problems	Chewing/Eating Problems
Tuberculosis		

Do you have any other medical condition we should be aware of? YES NO

If YES, explain ____

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature ____ Date ______________________

WELCOME

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information - Adult

Patient's Name ______________________________ Age ______ Birth Date ______________
First Middle Last

Nickname (if preferred) ______________________ Male Female

Home Phone ______________ Cell Phone ______________ SS # ______________

Home Address ______________________ City, State, ZIP ______________
Street

Employer ______________________ Email ______________________

Occupation ______________________ How Long ______________

General Dentist ______________ How did you find out about our office? ______________

Have we treated another member of your family? YES NO If YES, Name ______________
First Middle Last

What are the main concerns that you would like orthodontics to accomplish? ______________

Have you visited an orthodontist before? YES NO If YES, for what reason? ______________

Insurance Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

Primary

Insurance Company Name ______________ Insurance Company Phone ______________

Insurance Company Address ______________ Group or Plan ______________

Insured's Name ______________ Insured's Birthdate ______________

Relationship ______________ Insured's SS # ______________

Insured's Employer ______________ Employer's Address ______________

Secondary

Insurance Company Name ______________ Insurance Company Phone ______________

Insurance Company Address ______________ Group or Plan ______________

Insured's Name ______________ Insured's Birthdate ______________

Relationship ______________ Insured's SS # ______________

Insured's Employer ______________ Employer's Address ______________

Dental and Medical History

Are you currently under the care of a physician? YES NO If YES, for what reason? ____________________

Physician ____________________ Phone # ____________________

History of major illness? YES NO If YES, please describe ____________________

Any sensitivities or allergies? YES NO If YES, please list ____________________

Currently taking any medications? YES NO If YES, please list ____________ Amount/Dose ____________

Have you been treated for any of the following?

Arthritis	Blood Disorder	Diabetes	Heart Condition	Tuberculosis
Asthma	Cancer	Epilepsy	Nervous Disorder	High Blood Pressure

Do you require antibiotics before dental treatment? YES NO If YES, explain ____________________

Have there been injuries to your face, mouth or chin? YES NO

Has you ever had pain/tenderness in the jaw joint (TMJ/TMD) YES NO

Do/Did you have any of the following habits?

Grinding Teeth	Finger/Thumb Sucking	Tongue Thrusting
Chronic Mouth Breathing	Speech Problems	Chewing/Eating Problems
Tuberculosis		

Do you have any other medical condition we should be aware of? YES NO

If YES, explain ____________________

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature ____________________ Date ____________

Consent for Use and Disclosure of Health Information and Release Form

PATIENT INFORMATION

Patient's Name ____________________ DOB: ____/____/______

Address ____________________ City __________ State _____ Zip ______

Home Phone (____) ____________________ Work Phone (____) ______________

Cell Phone (____) ____________________ Email ____________________

Our Practice has always safeguarded and protected our valued patient's personal and health information. These safeguards meet or exceed the 2003 **H.I.P.A.A.** *(Health Insurance Portability and Accountability Act), under the Department of Health and Human Services* requirements to include the September 2013 *"Omnibus"* updated Privacy regulations. Our Practice Privacy policies, in accordance, allows us to use your personal information for "Normal and Customary" services when required communication within the Healthcare profession, both clinical and administrative to include but not limited to: Consultations with another Healthcare professional such as your medical doctor or another dental specialist about your treatment or progress, assisting with patient insurance, appointment reminders, account financial information and laboratory cases.

□ ***Request For Exemption(s)***- Mark this box if you wish for any of your information NOT to be used for normal and customary practices within the Healthcare Profession, specifically write your request for exemption(s) or limitations(s) below. *Example: No calls to work phone.*

**Practice Use Only: Exemption(s) declined, Patient informed. Signature/Date:______________*

Who May We Release Information to: Please specify anyone you authorize our Practice to release information and what type on information we may give out, if requested and approved, about you, your treatment, progress or account. Usually this is a spouse or significant other, Parent or guardian, Grandparents, adult children or whomever you choose to authorize our Practice and our Healthcare Associates to release information to.

PLEASE PRINT COMPLETE NAME(S) AND LEGAL RELATIONSHIP TO PATIENT.

____
Complete Name Relationship Date
Type of Information authorized to release:
□ **NO RESTRICTIONS FOR THIS INDIVIDUAL**
□*Treatment/Condition* □*Financial/Administration*

____
Complete Name Relationship Date
Type of Information authorized to release:
□ **NO RESTRICTIONS FOR THIS INDIVIDUAL**
□*Treatment/Condition* □*Financial/Administration*

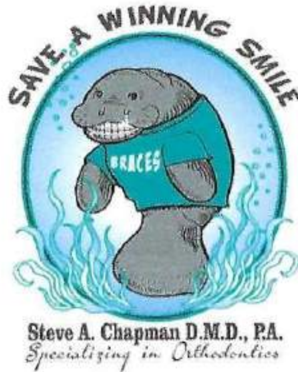
____
Complete Name Relationship Date
Type of Information authorized to release:
□ **NO RESTRICTIONS FOR THIS INDIVIDUAL**
□*Treatment/Condition* □*Financial/Administration*

____
Complete Name Relationship Date
Type of Information authorized to release:
□ **NO RESTRICTIONS FOR THIS INDIVIDUAL**
□*Treatment/Condition* □*Financial/Administration*

I have read, reviewed and considered the contents of this Consent form and was given a copy of the Practice's "Notice of Privacy Practices." I understand, that by signing this Consent form, I am giving my legal consent for your disclosure and use of mine and/or my dependents *(minor Child or other person(s) whom I am the legal guardian of)* protected Private personal and health information in any form deemed needed in the Practice's professional judgement and in accordance with our normal and customary Privacy and Security practices. You have the legal right to amend or revoke this consent given at any time by providing us written notice.

____
Signature (Adult) Date
□ Patient □ Parent □ Legal Guardian □ Other *(Specify)*

____
Signature (Adult) Date
□ Patient □ Parent □ Legal Guardian □ Other *(Specify)*



Standard Artist Release For The Office Of Dr. Steve Chapman D.M.D., P.A.

I hereby authorize the office of Dr. Steve Chapman D.M.D.,PA the right (all rights) to any picture, photograph, video, or similar data used for (or related to) a orthodontic purpose. I also authorize said producer, without limitation the right to reproduce, copy, cable-cast, exhibit/publish, display on any social media site, or distribute and such picture. This being said I expressly waive any rights or claims I may have against your office and/ or any of its affiliates, subsidiaries, or assignees except as outlined in the contract.

________________________ ________________________

Print Parent/Guardian Name Signature Date

________________________ ________________________

Print Patient Name Signature Date