britton orthodontics

Specialists in Orthodontics for Children and Adults

Patient Information

Date _____

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Birth date _____ School _____

Brothers (names & ages) _____ Sisters (names & ages) _____

Preferred Appointment Reminder Method q Email _____ q Text _____

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

Who is your General Dentist? _____

Responsible Party Information

Name _____ (Last) _____ (First) _____ (Middle) Social Security # _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Years at this address ___/___ (Years/Months) Do you q Own q Rent Email address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Relationship to Patient _____ Birth date _____ Marital Status _____

Employer _____ Years Employed _____ Occupation _____

Spouse's Name _____ (Last) _____ (First) _____ (Middle) Cell Phone _____

Spouse's Employer _____ Occupation _____ Work Phone _____

Dental Insurance

Policyholder's Name _____ Policyholder's Social Security # _____

Policyholder's Address _____ Policyholder's Phone # _____

Policyholder's relationship to Patient _____ Policyholder's Birth date _____

Insurance Company _____ Ins. Co. Phone _____ Group No. _____

Policyholder's Employer _____ Identification # _____

Do you have dual coverage? q Yes q No If yes:

Policyholder's Name _____ Policyholder's Social Security # _____

Policyholder's Address _____ Policyholder's Phone # _____

Policyholder's relationship to Patient _____ Policyholder's Birth date _____

Insurance Company _____ Ins. Co. Phone _____ Group No. _____

Policyholder's Employer _____ Identification # _____

As a courtesy to our patients we file your insurance claim forms. We will attempt to obtain as much insurance coverage for you as possible. However, please understand that you are responsible, in full, for all charges rendered. Any insurance estimates provided by this office should be considered a guideline only. When final insurance payment is received, your account will be reconciled.

I authorize the release of any information necessary to process my insurance claim and, also, hereby authorize payment of insurance benefits to Bloyce H. Britton III, DDS, MS.

I understand that where appropriate, credit bureau reports may be obtained.

Updated 11/13/17

_____ _____

Signature Date

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Medical & Dental History

Your answers to the following questions are extremely important for an accurate diagnosis. Thank you for your patience in answering the following questions.

Your Name: _____ Nickname: _____

		Yes	No
1.	Have you recently (within the past year) received treatment from a medical professional? (Chiropractor, Family Physician, Internist, Psychiatrist, Osteopath, etc.)_____ For what? _____	q	q
2.	Are you taking any medication? (name of medicine) _____	q	q
3.	Do you consider yourself to be a "nervous person"?_____	q	q
4.	Have you ever had: (Please check all that apply) q Rheumatic fever q Heart disease q Diabetes q Asthma q Hay fever q Allergies (seasonal) q Convulsions q Positive HIV test (AIDS) q Tonsillitis q Hepatitis q Prolonged bleeding q Photosensitivity or glaucoma q Allergies to Medication/Other (please list) _____		
5.	Have you been ill for more than 5 days in the last year? Name of illness: _____	q	q
6.	Have you ever had any extensive X-ray therapy for **tumors or cancer**? _____	q	q
7.	Have you ever had operations on, or injuries to the head or neck? If so, when? _____ _____	q	q
8.	Have you ever received a severe blow on the teeth or jaws? If so, where? _____ _____ Approximately at what age? _____	q	q
9.	Have you been to a dentist in the last 12 months?_____ Cooperation with the dentist has been: q Excellent q Good q Fair q Poor Approximate month and year of your last dental check up _____	q	q
10.	Do you brush their teeth in the q Morning q After lunch q After dinner q Before retiring How often do you floss your teeth?_____		
11.	Do you constantly have sore or bleeding gums? _____	q	q
12.	Have any of your teeth been removed? If so, q permanent teeth q baby teeth_____	q	q
13.	Have you ever sucked your fingers, thumb, lips or tongue? _____ If yes, do you still? _____ If not presently, at what age did it stop? _____	q	q
14.	Do you bite your lips, tongue, fingernails, pencil or other objects?_____	q	q
15.	Are you aware of q gritting, q grinding, or q clenching your teeth q at night? q daytime? _____ Do you have frequent (4-5 times per week) headaches or neck aches? _____ Do you wake up in the morning with sore jaw muscles? _____	q q q	q q q
16.	Do you have any clicking or snapping of the joint of the lower jaw when opening or closing the mouth?_____ Have you ever received treatment for jaw joint disorder? If so, when? _____	q q	q q
17.	Do you have any difficulty in chewing or swallowing food? _____ Please describe: _____	q	q
18.	Have your tonsils and/or adenoids been removed? _____ Do you breathe through your **mouth** most of the time?_____	q q	q q
19.	Do you play a wind musical instrument? What kind? _____	q	q

Please continue on back [

20. Who first noticed the need for orthodontic treatment? q Dentist q You q Other

21. Is your attitude toward wearing orthodontic appliances one of
    q Eagerness q Willingness q Complacency q Resignation q Antagonism? Yes No

22. Has another member of your family had orthodontic treatment? If so, who? _____ q q

23. Have you ever had "braces" before? _____ q q
    Approximate time period: From _____ to _____

24. Does any member of your family or close relatives have similar arrangement of teeth or similar appearance of jaws? _____ q q

25. Are you interested in having orthodontic treatment for: (Check all that apply)
    q Appearance q Better digestion q Better speech q On advice of dentist q On advice of friends

26. Are you dissatisfied with the appearance of your teeth? _____ q q
    If so, please describe what you would like to have fixed: _____
    _____
    _____
    _____
    _____

27. Are you concerned about other aspects of your facial features (nose, chin, jaw line, etc.)? _____ q q
    If so what in particular? _____
    Have you ever been teased about the appearance of your teeth or face? _____ q q

Hobbies/Interests: _____
_____
_____
_____

We make every attempt to schedule appointments for convenience, but orthodontic appointments may infringe on your work/school schedule.

Please initial that you understand about appointment scheduling _____

I understand that records are stored electronically and that an electronic copy shall be considered an original for all purposes.

This form completed by (Please sign) _____ Date _____

Thank you.

For Office Use Only

_____ /_____ /_____ _____
Dolphin Updated Initials

Notes:

CC:

Findings:

Plan:

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Britton Orthodontics Photography Consent Form/Release

Britton Orthodontics on occasion takes photos and videos of patients to be used in the offices, on the Britton Orthodontics website, Facebook, news print, and related publications. This list is not inclusive, but serves to demonstrate situations in which patients may be photographed or filmed.

_____ Outside the office – I give permission to Britton Orthodontics to use my photo(s) or video(s) with (first name and last name initial only) or without my name for any lawful purpose, including such purposes as marketing, illustration, advertising, and Web content.

_____ Inside the office – I give permission to Britton Orthodontics to use my photo(s) or video(s) for any illustration **within** the office only.

_____ I request that my photo(s) or video(s) **not** be used in association with Britton Orthodontics events/functions/publications.

_____

Printed Patient Name

_____

Signature of parent/guardian/adult patient

_____

Date

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Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

If your first date of service with us was due to an emergency, we will try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

I have received Britton Orthodontics Privacy Notice.

_____
Print Name

_____ _____
Patient's Signature or Personal Representative's Signature Date

_____
If Personal Representative, describe relationship

Britton Orthodontics staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Notice of Privacy Practices? [ ] Yes [ ] No

2. If you answered "No" above, please explain why the patient did not sign an acknowledgement form and Britton Orthodontics efforts in trying to obtain the patient's signature (check all that apply):

[ ] Patient Unable to Comprehend
[ ] Patient Communication Barrier
[ ] Legal Representative not Available
[ ] Other:_____
[ ] Patient/Legal Representative Left before Signature Obtained
[ ] Patient bypassed Registration – Not Available

3. Completed by:

_____ _____
Employee Signature Date

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013, 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 Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

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 have provided a description and an 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 health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, 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 health information to your family or 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 patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- 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
- Notify 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 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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of 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. These oversight activities include audits, investigations, 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 a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you 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, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

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

Other Uses 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 before using or disclosing your PHI for purposes other than those provided for in this Notice (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 in 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 listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the 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 health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, 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 the case where the disclosure is to a health plan for purposes of carrying out 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 Communication. You have the right to request that we communicate with you about your health information 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 of 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 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. 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 protected health information 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 Notice electronically on our Web site or by electronic mail (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 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 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. Department of 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. Department of Health and Human Services.

Our Privacy Official: Holly Pirruccello
Telephone: 210-497-6688 Fax: 210-545-1884
Address: 1130 E. Sonterra Blvd., Suite 100, San Antonio, TX 78258
E-mail: info@brittonortho.com