Orthodontics for Children and Adults

Don L. Wilson, DDS, MSD

Confidential Patient Information

Legal First Name:_____

Legal Last Name: _____

Address: _____

City: _____State: ____ Zip:_____

Birthdate: _____ ☐ Male ☐ Female

Dentist: _____

Dentist's Address: _____

_____

Emergency Contact:

Name of nearest relative NOT living with you:

_____

Emergency Contact Phone: _____

Relationship to Patient: _____

How did you hear about our office?

☐ Dentist: _____ ☐ Patient:_____ ☐ Parent of Patient:_____

☐ Yelp ☐ Facebook ☐ Google ☐ Ad: _____ ☐ Other:_____

The American Association of Orthodontists recommends all children have a check-up with an orthodontist by age 7.
We will send you a reminder when a sibling is reaching age 7 to come in for a complimentary exam.

Sibling Name_____ Birthdate: _____ ☐ Male ☐ Female

Sibling Name_____ Birthdate: _____ ☐ Male ☐ Female

Responsible/Financial Party

(complete blue items below if you are an adult patient)

Relationship to Patient:

☐ mother ☐ father ☐ other_____

First Name: _____

Last Name: _____

Address: _____

City: _____State: ____ Zip:_____

Primary Phone: _____ ☐ home ☐ cell

Would you like to receive CALL reminders to this #? yes / no

Would you like to receive TEXT reminders to this #? yes / no

Is it ok to leave treatment & financial messages at this #? yes / no

Social Security #: _____

Email: _____

Would you like to receive EMAIL reminders? yes / no

Is it ok to send treatment & financial messages to this email? yes / no

☐ single ☐ married ☐ divorced

Other Responsible Party

(another person you authorize to access patient info)

Relationship to Patient:

☐ mother ☐ father ☐ other_____

First Name: _____

Last Name: _____

Address: _____

City: _____State: ____ Zip:_____

Primary Phone: _____ ☐ home ☐ cell

Would you like to receive CALL reminders to this #? yes / no

Would you like to receive TEXT reminders to this #? yes / no

Is it ok to leave treatment & financial messages at this #? yes / no

Social Security #: _____

Email: _____

Would you like to receive EMAIL reminders? yes / no

Is it ok to send treatment & financial messages to this email? yes / no

☐ single ☐ married ☐ divorced

(continued on reverse side)

Patient Health Information

Medical Doctor's Name: _____

Medical Doctor's Phone: _____

YES	NO		YES	NO	
☐	☐	Pregnant	☐	☐	Injuries to face, jaw, mouth or teeth
☐	☐	Latex allergy (reaction to balloons, rubberbands, etc.)	☐	☐	Any speech problems/therapy
☐	☐	Other allergy _____	☐	☐	Grind or clench teeth
☐	☐	Current medications _____	☐	☐	Pain, tenderness or noise in jaw
☐	☐	Heart condition _____	☐	☐	Discomfort from teeth or gums
☐	☐	Frequent headaches	☐	☐	Are there any other dental/medical problems of which Dr. Wilson should be aware
☐	☐	Hepatitis			_____
☐	☐	HIV/AIDS			_____

Dental Insurance Information

Do you have insurance that covers orthodontic treatment? ☐ YES (complete below) ☐ NOT SURE (complete below) ☐ NO

Insurance Company Name: _____ Insurance Company Phone: _____

Insurance Company's Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Employer's Name: _____

Subscriber's Social Security #: _____ Subscriber's Birthdate: _____

Our office will send a claim to your insurance company on your behalf. The signer of the financial agreement with Don L. Wilson, DDS, MSD, Inc. is responsible for the financial contract in its entirety. Any non-payment or claim denial from the insurance company is not the responsibility of Don L. Wilson, DDS, MSD, Inc.

Signature: _____ **Date**: _____

_____ ***(Initial)*** Cancellation policy: I understand I must give at least 1 (one) business day's notice to change or cancel my appointment in order to avoid being charged a $25 fee.

_____ ***(Initial)*** The information provided is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of changes to any information or the patient's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services that the patient may need. I understand that I am responsible for the payment of services rendered.

_____ ***(Initial)*** I authorize the release of dental/medical/insurance records to other dental/medical offices involved in the patient's continued orthodontic/dental treatment.

_____ ***(Initial)*** I acknowledge that I have received your NOTICE OF PRIVACY PRACTICES containing a complete description of the uses and disclosures of my health information. I understand that the organization has the right to change its NOTICE OF PRIVACY PRACTICES, and that I may contact this organization at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Your Right to Privacy

Information for Patients

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

You will be asked to sign an acknowledgement that states you have received the privacy notice.

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 01/01/11, 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.

Effective Date of this Notice: April 14, 2003
Revised: September 10, 2016

Permitted Uses and Disclosures

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. Example: During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. Example: The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

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. Example: We will share information about you with such insurers or other business associates as necessary to obtain these services.

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.

Other Disclosures and Uses

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, e-mail messages, postcards, or letters).

Your 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 you $1.00 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the 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. Contact us using the 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, healthcare 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-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.

Complaints

Complaints about this Notice of Privacy Practices or how Don L. Wilson, DDS, MSD, Inc. handles your health information should be directed to our Privacy Official:

Charis Santillie
Business Manager
Don L. Wilson, DDS, MSD
7250 Redwood Blvd.
Suite 107
Novato, CA 94945
Phone: (415) 878-0240
Fax: (415) 878-0242
Email: charis@wilsonortho.com

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

We cannot, and will not, require you to waive the right to file a formal complaint as a condition of receiving treatment with the practice.

We cannot, and will not, retaliate against you for filing a formal complaint.