BEAVERTON ORTHODONTICS - PC
Steven W. Black, DDS

14795 SW Murray Scholls Drive, Suite 119
Beaverton, OR 97007
503.524.0524
www.beavertonortho.com

PATIENT INFORMATION and HEALTH HISTORY

Date_____

Patient's name_____ Gender_____
FIRST MIDDLE LAST

Patient's preferred name_____ Birthdate_____

Adult accompanying minor today_____
NAME RELATIONSHIP TO PATIENT

Address_____
STREET CITY ZIP

_____
HOME phone CELL phone WORK phone/Employer name

Please list your preferred methods for appointment reminders:_____
Email

_____ _____
Phone # for text messages Phone # for voice mail

Other family members treated here_____

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

What is the reason for your visit today?_____

RESPONSIBLE PARTY INFORMATION if patient is a minor

Parent/Guardian_____ Relationship to patient_____

Address_____
STREET CITY ZIP

Phone_____
HOME CELL WORK

EMAIL(for appointment reminders)_____ Employer_____

Parent/Guardian_____ Relationship to patient_____

Address_____
STREET CITY ZIP

Phone_____
HOME CELL WORK

EMAIL(for appointment reminders)_____ Employer_____

IF DIVORCED, CHILD LIVES WITH: Mother_____ **Father** _____ **Other(s) e.g. Step-parent(s)**_____**(please list names)**

_____

EMERGENCY CONTACT

Name_____ Phone_____ Relationship to patient_____

ORTHODONTIC INSURANCE

Primary Insurance

Insurance Company_____

Insurance Company phone_____

Insured's name_____

Insured's address_____

_____

Ins. ID#_____ Birthdate_____

Insured's relation to patient_____

Secondary Insurance

Insurance Company_____

Insurance Company phone_____

Insured's name_____

Insured's address_____

_____

Ins. ID#_____ Birthdate_____

Insured's relation to patient_____

I authorize insurance payment directly to Beaverton Orthodontics, PC the benefits otherwise payable to me.

Signature_____ **Date**_____

HEALTH HISTORY

Physician_____ Date of last visit_____

Address_____ Phone_____

Please circle Yes or No (If Yes, please fill in details)

Yes **No** Taking any medications?_____

Yes **No** History of major illness?_____

Yes **No** Surgeries?_____

Yes **No** Tobacco use?_____

Female patients only:

Yes **No** Has menstruation started?_____

Yes **No** Currently pregnant?_____

Check any of the medical conditions below that you have had or currently have (or check NONE OF THE ABOVE):

_____Asthma/Lung Problems	_____Disabilities	_____Hepatitis/Liver Problems
_____Attention Deficit	_____Drug/Alcohol Abuse	_____Herpes
_____Blood Disorder/Transfusion	_____Epilepsy/Seizures/Fainting	_____HIV/Aids
_____Bone Disorder/Osteoporosis	_____Gastrointestinal Disorders	_____Psychiatric
_____Cancer/Chemotherapy	_____Headaches	_____STD's
_____Diabetes	_____Heart Problems	_____Tuberculosis

_____**NONE OF THE ABOVE**

Other medical conditions?_____

Circle any confirmed allergies: Acetominophen Aspirin Ibuprofen Latex Nickel Lactose Intolerance

Other allergies(please explain)_____

DENTAL HISTORY

General Dentist_____ Date of last visit_____

Yes **No** History of lost or chipped teeth?_____

Yes **No** Injury to face, mouth or teeth?_____

Yes **No** Do the gums bleed when brushing?_____

Yes **No** Is there a thumb habit or tongue thrust?_____

Yes **No** Mouth breather?_____

Yes **No** Ever seen an orthodontist? Who/When?_____

Yes **No** Awareness of teeth clenching during the day?_____

Yes **No** History of grinding teeth?_____

AUTHORIZATION FOR ORTHODONTIC EVALUATION

I understand the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of changes in medical status. I authorize Steven W. Black, DDS to perform a complete orthodontic evaluation. ***I consent to receiving electronic appointment reminders and can opt-out at any time by text, email, or voice.***

Signature:_____ **Date:**_____

BEAVERTON ORTHODONTICS, PC

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.

Our Legal Duty

We are required to maintain the privacy of your Protected Health Information (PHI). We are also required to provide you this Notice and follow the practices that are described herein while this notice is in effect. This notice takes effect 4/16/12, and will remain in effect until we replace it. We may change our privacy practices and the terms of this notice, provided the changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and provide the new one at our practice location, and distribute it upon request. You may request a copy of this Notice at any time. For more information, please contact us at 503-524-0524.

Your Authorization

In addition to our use of your PHI as described below, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. 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.

Uses and Disclosures of Health Information

Treatment: We may use or disclose your PHI to provide, coordinate, or manage your health care/related services.
Payment: We may use and disclose your PHI to obtain payment for services we provide to you.
Healthcare Operations: We may use/disclose your PHI for healthcare operations, including quality assessment/improvement, reviewing competence or qualifications of healthcare professionals, evaluation practitioner/provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.
Personal Representative: We must disclose your PHI to you. If you agree so, we may disclose PHI to your personal representative.
Persons Involved in Care: We may use or disclose PHI to notify or assist in the notification of a family member, your personal representative, or another person responsible for your care, of your location, general condition, or death. If you are present, then prior to use or disclosure of your PHI, we provide you with an opportunity to object. In the event of your absence or incapacity or in an emergency, we will disclose PHI based on a determination using our judgment and disclosing only 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 orthodontic supplies, x-rays, or other similar forms of PHI.
Disaster Relief: We may use or disclose your PHI to assist in disaster relief efforts.
Marketing Health-Related Services: We will not use your PHI for marketing communications without your written authorization.
Required by Law: We may use of disclose your health information when we are required to do so by law.
Public Health and Public Benefit: We may use or disclose your PHI to report abuse, neglect, domestic violence; to report disease, injury, and vital statistics to the FDA; for health oversight activities; for certain judicial/administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.
Decedents: We may disclose PHI about a decedent as authorized or required by law.
National Security: We may disclose PHI of Armed Forces personnel under certain circumstances. We may disclose PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the PHI of an inmate of patient under certain circumstances.
Appointment reminders: We may use or disclose your PHI to provide you with appointment reminders such as voicemails, postcards, or letters.

Patient Rights

Access: You must request in writing to obtain access to your health information. You have the right to look at or receive copies of your health information, with limited exceptions. We will charge you a reasonable fee for copying expenses and staff time. To obtain a form to request access, contact our Office Manager or send us a letter to our office address.
Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI for the last 6 years, but not before April 14, 2003.
Restriction: You have the right to request restriction of disclosure of your PHI. Your request must be in writing and must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, but if we do, we will abide by our agreement (except in an emergency). We must comply with a request to restrict the disclosure of PHI to a health plan for purposes of payment or health care operations (as defined by HIPAA) if the PHI pertains solely to a healthcare item or service for which we have been paid out of pocket in full.
Alternative Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. Your request must be 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.
Amendment: You have the right to request that we amend your PHI. 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically.

Questions and complaints

If you want more information, or have questions or concerns, please contact our Office Manager/Compliance Officer. If you are concerned with our handling of your PHI, you may complain to our Office Manager/Compliance Officer at 503-524-0524. You may also submit a written complaint to the US Dept of Health and Human Services. We support your right to the privacy of your PHI, and we will not retaliate in any way if you choose to file a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Print name:_____
(Custodial/Responsible Party/Guardian)

Signature:_____
(Custodial/Responsible Party/Guardian) Date