Fesler Orthodontics • Michael Fesler, DDS, MS
160 E. FM 544 • Suite 98 • Murphy, Texas 75094 • 972-424-2221

fesler
ORTHODONTICS

Patient Information

Patient Name____Date____/____/____

Address______________________________City_______________State______Zip________

Home Ph. ____-____-_____Work Ph. ____-____-_____ SS#_____-_____-_____ Birth date____/____/____

How did you hear about our office? _____________________ Patient's Dentist __________________

Has any member of your family previously undergone Orthodontic treatment? ____________________

Email Address (Used only for correspondence from our office) ____________________________________

Responsible Party Information

Parent/Guardian________________________________ Relationship to patient ______________

Mailing Address ____________________________City ______________State_____Zip ________

How many years at current address? _______ Home Ph. _____-_____-_____ Work Ph. _____-_____-_____

SS# ______-_____-______ Birth date_____/_____/_____ Drivers License # ______________________

Employer ____ No. of years__________

Employer address ____ Occupation_______________

Other parent (if address is different) ____

Mailing Address____________________________City______________State_____Zip ________

Home Ph. ____-____-_____Work Ph. ____-____-_____ SS#_____-_____-_____ Birth date____/____/____

Employer____ No. yrs _______

Employer address____ Occupation________________

Emergency Contact (other than guardian) ____

Relationship _____________________Daytime Ph. ____-____-_____Alternative Ph. ____-____-_____

Insurance Information

Insured's Name ____ Insured's SS # _____-_____-_____

Insurance Company __________________________ Policy # ______________ Group # ___________

Insurance Company Address ____

Insurance Company Phone # ____-____-_____ Insured's Employer ______________________________

Secondary Insurance (if applicable): ____

I certify that all of the above information is true and it is my responsibility to inform this office of any changes.

Signature (Guardian's signature if a minor)____________________________________Date ___/___/___

Relationship to the patient __________________

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Medical History

Please Check Yes or No if the patient has or has ever had…

Y	N	
( )	( )	Joint swelling or Arthritis
( )	( )	Bone Disorders
( )	( )	Heart Problems
( )	( )	Diabetes
( )	( )	High Blood Pressure
( )	( )	Kidney Problems
( )	( )	Rheumatic Fever
( )	( )	Hepatitis or Liver Problems
( )	( )	Emotional or Psychological Problems
( )	( )	Tuberculosis
( )	( )	AIDS / HIV
( )	( )	Anemia
( )	( )	Asthma
( )	( )	Epilepsy
( )	( )	Prolonged Bleeding
( )	( )	Endocrine problems, Thyroid problems
( )	( )	Tonsils Removed
( )	( )	Adenoids Removed

Please list dates and specifics for all "Yes" answers

____

____

____

List any allergies:

____

List medications presently being taken:

____

____

List any serious illness or operation not listed above:

____

Has a physician ever advised the patient to take antibiotics prior to dental appointments? Y / N

Is the Patient currently under a physician's care? Y / N

Physician's Name ___________________________________

Reason ____

Dental History

Please Check Yes or No if the patient has or has ever had…

Y	N	
( )	( )	Any injury to face, mouth, teeth?
( )	( )	Thumb, finger or lip sucking habit(s)?
( )	( )	Any speech problems?
( )	( )	Mouth breathing when asleep, awake?
( )	( )	Any known missing permanent teeth?
( )	( )	Any known extra permanent teeth?
( )	( )	Any teeth removed by extraction? When?______
( )	( )	Tongue thrust?
( )	( )	Any wind instruments played?
( )	( )	Clenching or Grinding of teeth?
( )	( )	Chronically sore or bleeding gums?
( )	( )	Jaw Pain, popping, grinding, locking?
( )	( )	Difficulty chewing or swallowing food?
( )	( )	Frequent Headaches? If Yes, how frequent?______
( )	( )	Muscle tenderness or stiffness in neck/jaw?
( )	( )	Ringing in ears, dizziness?
( )	( )	Previous treatment for TMJ or joint problems?

Please list dates and specifics for all "Yes" answers

____

____

____

Does patient visit his/her general dentist regularly? Y / N

Has an Orthodontist been consulted previously? Y / N

Reason: ____

Has patient experienced a sudden increase in height? Y / N

Does any member of the family or close relative(s) have a similar arrangement of the teeth or similar appearance of the jaws?

Explain ____

____

List any other dental information known, and not listed above

____

____

The above information is true to the best of my knowledge, and I understand that it is my obligation to update this information as changes become known to me.

Patient Name ___________________________________

Patient/Parent/Guardian Signature ______________________________ **Date**___/___/___

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, ____ , have received a copy of this office's Notice of Privacy Practices.

____
Signature

____
Date

For office use only:
We attempted to obtain written acknowledgement of receipt of our 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 (specify below)

____

____

____

Fesler Orthodontics, P.A.

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 practices, we will change this Notice and make a 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, physician, 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 qualifications 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 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Check-in: Patients' names (but not health information) may be visible on our waiting room check-in system.

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 a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. 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 for each page, $75 per hour for staff time to locate and copy your health information, plus postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy policy or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or 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 complain 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.

Contact Officer: Michael Fesler, DDS, MS
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