5656 Bee Caves Road, Ste C100 - Austin Texas 78746
Office: 512.732.2500 Fax: 512.732.2601
www.westlakefamilyortho.com

NEW PATIENT FORM

Name: ____ DOB: ________________________

Email: ____

Home Phone: _________________ Mobile Phone: _________________ Work Phone: ________________

Address: ______________________________ City: ______________ State: ________ Zip: _______

Responsible Party Name: ____ Phone: ______________

Relationship to Patient: (Circle) **Self** **Mother** **Father** **Legal Guardian** **Spouse**

Address: ______________________________ City: ______________ State: ________ Zip: _______

Home Phone: __________________ Mobile: _______________________ Work: _________________

Other Parent Name: _______________________________ Mobile: _________________________

Relationship to Patient: (Circle) **Self** **Mother** **Father** **Legal Guardian** **Spouse**

INSURANCE INFORMATION: (SKIP this section if you have already provided information at the initial call)

Do You Have Dental Insurance We Can Verify For You**?** **Yes** **No** Have We Already Been Given This Information? **Yes** **No**

Policy Holder Name: _________________________________ Policy Holder's DOB: ________________

Relationship to Patient: (Circle one) **Dependent** **Father** **Mother** **Partner** **Self** **Spouse**

Policy Holder Contact Number: _________________________________ Best Time To Call: _____________

Name of Insurance Company: _____________________________ Phone: _________________________

Member#/ID#/SSN: ____________________________________ Group Number: ___________________

Employer's Name: ____

PERSONAL INFORMATION:

Main Concerns for Your Visit Today: ____

Who May We Thank for Referring You? ______________________________ Number: _________________

Dentist: ____ Number: ________________

When Was Your Last Dental Check-Up? ____

Do You Have Any Dental Treatment To Be Complete? ____

Do You Have Immediate Family with Our Office: (Circle) **YES** **NO** **(Sister)** **(Brother)** **(Father)** **(Mother)**

Their Name(s): ____

What Options Are You Interested In To Straighten Your Teeth? **Invisalign** **Clear Braces** **Metal Braces**

ANY HEALTH PROBLEMS SUCH AS:

___LATEX Allergies **Yes** **No**

___ Blood Disorders **Yes** **No** If Yes, Please Explain: ____

____

___ Heart Murmurs **Yes** **No** If Yes, Are Antibiotics Required Before Invasive Dental Procedures? **Yes** **No**

Please Provide Treating Cardiologist Name and Number: ____

____

___ HIV or AIDS **Yes** **No**

___ Hepatitis **Yes** **No**

___ Diabetes (Circle) **Type A** **Type B** (juvenile)

Do You Smoke? **Yes** **No**

Do You Drink Tea Or Coffee? **Yes** **No**

Disabilities: **Yes** **No** If Yes, Please Explain: ____

Any Mental Health Concerns to be Aware of? ____

Are You Taking Any Medication? **Yes** **No** If Yes, Please List the Name and Dosages _________________________________

____

Do You Participant in Sports Requiring a Mouth Piece? **____ Yes** **____ No**

Any Other Health Concerns We Should Be Aware Of Before We Start Orthodontic Treatment?

____

____

You, Patient or Responsible Party, are encouraged to review the information contained in this Health History Disclosure Form and ask any questions you may have if you are unsure of your oral and physical health problems. Should any changes occur to this information, you are required to provide changes to WFO within a reasonable time frame.

I acknowledge my responsibility to adhere to the oral and health information provide.

I hereby acknowledge the receipt of my disclosures made above and is true and accurate to the best of my knowledge.

_________________________________ ___________ ____

Patient/Responsible Party Signature **Date** **Treatment Coordinator/Orthodontist Signature**

HIPPA

Westlake Family Orthodontics
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 (6/01/2016), 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.

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 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.

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 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 voice mail messages, postcards, or letters).

PATIENT 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. You may also request access by sending us a letter to the address at the end of this Notice. 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.

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 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.

Contact Officer: Travis Tomblyn
Telephone: 512-792-2500 Fax: 512-732-2601
E-mail: info@westfamilyortho.com
Address: 5656 Bee Cave Rd – Austin, TX 78746

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).

HHIPA Privacy Notice of Acknowledgement

February 5, 2018

Name: (Resposible Party or Self)____

Address: ____

City: ____

Regarding Patient: ______________________________________

To whom it may concern,

Federal law requires that we provide you with a copy of the Privacy Act at your request.

The Privacy Notice explains how we may use and disclose health information about you or your child(ren). We ask that you sign this form for our records so that we may document your receipt of the notice.

Privacy Officer: Chris Cheatham, Treatment Coordinator

I, _______________________________________, have (**received**) or (**declined**) a copy of the HIPPA" Notice of Privacy Practices". (By Choosing "Received"-A copy will be provided per patient request above.)

_________________________ __________ ________________________

Signature of Parent/Patient/Guardian Date Name Printed

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize **Westlake Family Orthodontics** to use and/or disclose the protected health information (PHI) described below to:

- General or Pediatric Dentist(s)
- Oral Surgeon(s)
- Invisalign
- Lab(s)
- Insurance(s)

Other: ____

(Please Add Spouse/Step Parents, If Applicable)

The following individually identifiable information:

- Orthodontic Records
- Treatment Plan
- Financial Agreement

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

Effective Period:
This authorization for release of information covers the period of healthcare while patient is receiving Orthodontic treatment at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or legibility for benefits will not be conditioned on whether or not I sign this authorization.

________________________________ Regarding Patient: ________________________________

Signature of Patient or Legal Guardian

____

Relationship to Patient

____

Date