



PLEASE FILL OUT AND BRING WITH YOU TO YOUR APPOINTMENT

Please contact us if you have any questions - we'd love to help

Patient Name LAST FIRST Birth Date Age
Nickname Patient's SS# Male Female
Address City State Zip
E-Mail Address Cell Number Text Messaging Yes No
Other family members treated here Patient's relationship to them
How did you hear about us?

RESPONSIBLE PARTY/ LEGAL GUARDIAN INFORMATION NUMBER 1

Name LAST FIRST Birth Date
Social Security # Drivers License # Relationship to Patient
Marital Status: Single Married Divorced Widowed E-Mail Address
Address City State Zip
Home Number Cell Number Work Number
Employer Occupation
Spouse's Name Spouse's Relationship to Patient

RESPONSIBLE PARTY/ LEGAL GUARDIAN INFORMATION NUMBER 2

Name LAST FIRST Birth Date
Social Security # Drivers License # Relationship to Patient
Marital Status: Single Married Divorced Widowed E-Mail Address
Address City State Zip
Home Number Cell Number Work Number
Employer Occupation
Spouse's Name Spouse's Relationship to Patient

HEALTH HISTORY

Dentist Name Date of Last Cleaning
Is the patient currently under a Physician's care? Yes No
If yes - Physician Name Physician Phone Number
Please list current medications
Please list any drug allergies
Has the patient ever taken any medication for osteoporosis? Yes No

If yes, please explain

Please select any that apply to the patient:
Pregnant Tuberculosis Cancer Latex Allergy Diabetes
Hepatitis A, B, or C Heart Murmur Congenital Heart Defect Rheumatic Fever HIV Positive/ AIDS
Hearing Impairment Asthma Kidney/Liver Problems Convulsions/Epilepsy Abnormal Bleeding
Jaw Clicking Finger Sucking Scarlet Fever Hemophilia Smoking

Please explain any of the above or list any special needs or concerns:

Signature (Guardian if a Minor) Date
I certify that all of the above information is true and it is my responsibility to inform this office of any changes.



INSURANCE INFORMATION FORM

PRIMARY DENTAL INSURANCE

Policy Holder's Name LAST _____ FIRST _____ Birth Date _____

Policy Holder's SS# _____ Policy Holder's Employer _____

Insurance Company Name _____ Effective Date _____

Policy # _____ Group # _____

Insurance Company Address _____

Insurance Company Phone _____ Orthodontic Coverage: Yes ___ No ___

I hereby authorize payment of the group insurance benefits directly to Central Texas Orthodontics:

Signature (Insured Person / Policy Holder) _____ Date _____

Office Use Only: Max _____ % up to \$ _____	Insurance Assigned / Not Assigned	Paid: Auto / Monthly / Quarterly
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SECONDARY DENTAL INSURANCE

Policy Holder's Name LAST _____ FIRST _____ Birth Date _____

Policy Holder's SS# _____ Policy Holder's Employer _____

Insurance Company Name _____ Effective Date _____

Policy # _____ Group # _____

Insurance Company Address _____

Insurance Company Phone _____ Orthodontic Coverage: Yes ___ No ___

I hereby authorize payment of the group insurance benefits directly to Central Texas Orthodontics:

Signature (Insured Person / Policy Holder) _____ Date _____

Office Use Only: Max _____ % up to \$ _____	Insurance Assigned / Not Assigned	Paid: Auto / Monthly / Quarterly
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review and keep a copy of Central Texas Orthodontics' Notice of Privacy Practices.

Guardian Name LAST _____ FIRST _____

Patient Name LAST _____ FIRST _____

Patient Date of Birth _____

Signature (Guardian if a minor) _____ Date _____

SCOTT V. LAW, DMD

CENTRAL TEXAS ORTHODONTICS

3106 SOUTH W.S. YOUNG DR. SUITE A-101 KILLEEN, TX 76542 ;

T: 254.526.8666 F: 254.526.4876

WWW.CENTEXORTHODONTICS.COM

ALL STAR SMILES ★ ALL STAR CARE



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PARENT GIVING CONSENT FOR CHILD PATIENT

Responsible Party/Guardian Name LAST FIRST

Patient Name LAST FIRST

Patient Date of Birth

SECTION B: PATIENT GIVING CONSENT FOR SELF

Patient Name LAST FIRST

Patient Date of Birth

SECTION C: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your/your child's protected health information to carry out treatment (radiographs, diagnostic records and any active treatment that is necessary), payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your/your child's protected health information. A copy of our Notice is available for you to review and/or keep for your records. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If changes are made to the privacy practices, a revision will be issued containing the changes. Those changes may apply to any of your/your child's protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting a copy from our office.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the office manager. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you/your child or to continue treating you/your child upon revocation of this Consent.

SIGNATURE:

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my/my child's protected health information to carry out treatment, payment activities and health care operations.

Signature

Date

If this consent is signed by a personal representative (other than parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU/YOUR CHILD 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 04/01/2003, and will remain in effect until changed.

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 or disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use or 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.

To Your Family, Friends and Persons Involved In Care: 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. We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. 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.

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 vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.

Court Orders and Subpoenas: We may disclose information in response to an appropriate court order or subpoena.

Law Enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

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, postcards or letters). We may also contact you to provide information about treatment alternatives or other health-related information that may be of interest to you.

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.

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 Website 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 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 the U.S. Department of Health and Human Services.

Contact Officer:

Danna Laine Doremus, Office Manager
ctortho@centexorthodontics.com
3106 South W.S. Young Drive, Suite A-101
Killeen, Texas 76542
254.526.8666 phone
254.526.4876 fax

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