

# CREEKVIEW ORTHODONTICS

## ADULT - INITIAL EXAMINATION

Welcome to our office. We appreciate your filling this form completely. Please inquire if you have any questions.

Date: \_\_\_\_\_

(Office use only: # \_\_\_\_\_ )

### PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	NICKNAME	BIRTHDATE	AGE
ADDRESS	CITY		ZIP	PHONE	
MALE [ ] FEMALE [ ] EMAIL: _____					
SINGLE [ ] MARRIED [ ] DIVORCED [ ] SPOUSE: NAME _____					
CHILDREN (names & ages) _____					
EMPLOYER _____ POSITION _____					
EMPLOYER ADDRESS _____ WORK PHONE _____					
HAS ANY MEMBER OF FAMILY UNDERGONE ORTHODONTIC TREATMENT? _____					
WHERE & WHEN ? _____ WHO MAY WE THANK FOR REFERRING YOU? _____					

### RESPONSIBLE PARTY INFORMATION

(ENTER 'S.A.A.' IF SAME AS ABOVE)

NAME _____				
ADDRESS	LAST	FIRST	MIDDLE	
	STREET	CITY	STATE	ZIP
NO. YEARS AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____				
PREVIOUS ADDRESS (IF LESS THAN 3 YRS.) _____				
	STREET	CITY	STATE	ZIP
DENTAL INSURANCE ID # (SSN if no ID) _____ EMAIL: _____				
BIRTHDATE _____ RELATIONSHIP TO PATIENT _____				
EMPLOYER _____ POSITION _____ NO. OF YEARS EMPLOYED _____				

### INSURANCE \* PRIMARY (Note: We will file a claim for your Secondary Insurance, but will accept payments from one carrier only)

Ins. Co. Name & Tel. _____	
Policy Holder Name & Insurance ID # (SSN if no ID) _____	
Employer Name & Address _____	
_____	Group Number: _____

<p>What do you not like about your teeth? (Reason for being here today): _____</p> <p>Name of General Dentist: _____</p> <p>Date of last Dental Exam: _____ Date of last Dental cleaning: _____</p> <p>Is patient in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have tonsils and adenoids been removed? (What age? _____) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has patient ever sucked thumb or finger? (Until what age? _____) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have any speech problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient a mouth breather? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient play a wind instrument? (Which instrument? _____) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have any discomfort in the jaw joints? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe _____</p> <p>Please list any allergies or drug sensitivities: _____</p> <p>If you are female, are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Has the patient ever had any of the following conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If yes, please check box below)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Rheumatic Fever</td> <td><input type="checkbox"/> Chronic Sinusitis</td> </tr> <tr> <td><input type="checkbox"/> Heart Murmur</td> <td><input type="checkbox"/> Aids/HIV</td> </tr> <tr> <td><input type="checkbox"/> Heart problems</td> <td><input type="checkbox"/> Asthma</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis (Type _____)</td> <td><input type="checkbox"/> Seizures/Convulsion</td> </tr> <tr> <td><input type="checkbox"/> Artificial Joints or Valves</td> <td><input type="checkbox"/> Psychiatric Care</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Venereal Disease</td> </tr> <tr> <td><input type="checkbox"/> Tuberculosis</td> <td><input type="checkbox"/> Smoker / Use Tobacco</td> </tr> </table> <p>If any other, please describe _____</p> <p>General Information: _____</p>	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Aids/HIV	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis (Type _____)	<input type="checkbox"/> Seizures/Convulsion	<input type="checkbox"/> Artificial Joints or Valves	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Smoker / Use Tobacco
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chronic Sinusitis														
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Aids/HIV														
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma														
<input type="checkbox"/> Hepatitis (Type _____)	<input type="checkbox"/> Seizures/Convulsion														
<input type="checkbox"/> Artificial Joints or Valves	<input type="checkbox"/> Psychiatric Care														
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Venereal Disease														
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Smoker / Use Tobacco														

I have read and understand the above questions. I will not hold this office responsible for any errors or omission in the completion of this form. If there are any changes later to the history form or the health status, I will so inform this practice. I also certify that I (or my dependent) assign my insurance benefits directly to Dr. Ghosh, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that where appropriate, credit bureau reports may be obtained.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## **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/YOUR CHILD'S HEALTH INFORMATION IS IMPORTANT TO US.**

---

### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your/your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your/your child's 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 03/20/03 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/your child for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your/your child's health information to a physician or other healthcare provider providing treatment to you/your child.

**Payment:** We may use and disclose your/your child's health information to obtain payment for services we provide to you/your child.

**Healthcare Operations:** We may use and disclose your/your child's 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/your child's health information for treatment, payment or healthcare operation, you may give us written authorization to use your/your child's 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/your child's health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your/your child's health information to you, as described in the Patient rights section of this Notice. We may disclose your/your child's health information to a family member, friend or other person to the extent necessary to help with your/your child's healthcare or with payment for your/your child's 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, or another person responsible for your/your child's care. If you are present, then prior to use or disclosure of your/your child's 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/your child's health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your/your child's health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your/your child's 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 health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

---

## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your/your child's 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.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your/your child's 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/your child's 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/your child's 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 child's privacy rights, or you disagree with a decision we made about access to your/your child's health information or in response to a request you made to amend or restrict the use or disclosure of your/your child's 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: Jay Ghosh

Telephone: 214-547-0001

Address: 1780 W. McDermott Dr., Ste 100, Allen, TX 75013

© 2002 American Dental Association. All Rights Reserved. Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

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

**CREEKVIEW ORTHODONTICS ♦ Jay Ghosh, D.D.S., M.S.**  
1780 W. McDermott Drive, Ste. 100, Allen, TX 75013 ♦ (214) 547-0001

**ACKNOWLEDGEMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICES**

(You May Refuse to Sign This Acknowledgement)

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

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

---

**For Office Use Only**

---

We attempt 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 (Please Specify)

---

**CONSENT FOR USE AND DISLCOSURE OF HEALTH INFORMATION**

---

**SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient NAME: \_\_\_\_\_ Patient Social Security #: \_\_\_\_\_

**SECTION B: TO THE PATIENT-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, 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 our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your/your child’s protected health information, and of other important matters about your/your child’s protected health information. A copy of our Notice accompanies this Consent. 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 we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain 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 contacting:

Contact Person: Jay Ghosh            Telephone: 214-547-0001  
Address: 1780 W. McDermott Dr., Ste 100, Allen, TX 75013

**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 Contact Person listed above. 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 or to continue treating you if you revoke 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: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

---

**REVOCAION OF CONSENT**

I revoke my Consent for your use and disclosure of my/my child’s protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(You are entitled to a copy of this consent after you sign it. Include completed consent in the patient’s chart)