ATLAS ORTHODONTICS

Date: _____

Patient's Name: _____
Last First Middle

General Dentist: _____ Date of Most Recent Check Up/Cleaning: _____

Birthdate: _____ Email: _____

Cell Phone: _____ Alternative Phone: _____

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

Residence Address: _____
Street City Zip

Mailing Address: _____
Street City Zip

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone number: _____

Relationship to Patient: _____

INSURANCE INFORMATION

Insured's Name: _____ DOB: _____

Insurance Company: _____ Insurance Company Phone: _____

Group #: _____ Insurance ID/Insured Soc. Sec. #: _____

Insurance Company Address: _____

Does Patient Have Dual Coverage? YES NO If YES, please continue:

Insured's Name: _____ DOB: _____

Insurance Company: _____

Group #: _____ Insurance ID/Insured Soc. Sec. #: _____

Insurance Company Address: _____

I authorize Atlas Orthodontics to submit claims to my insurance company on my behalf. I authorize dental insurance payment to be assigned to Atlas Orthodontics/Dr. E. Stefan Alexandroni

Patient Signature: _____ Date: _____

ATLAS ORTHODONTICS

For the following questions mark YES, NO or Don't Know/Understand (DK/U). A thorough and complete health history is vital to a proper orthodontic evaluation.

Patient's Name _____ Date _____

Now or in the past has patient had?

- ☐ YES ☐ NO ☐ DK/U Eye, ear, nose or throat conditions?
- ☐ YES ☐ NO ☐ DK/U Fainting spells, seizures, epilepsy or neurological problems?
- ☐ YES ☐ NO ☐ DK/U Rheumatoid or arthritic conditions?
- ☐ YES ☐ NO ☐ DK/U Endocrine or thyroid problems?
- ☐ YES ☐ NO ☐ DK/U Kidney problems?
- ☐ YES ☐ NO ☐ DK/U Diabetes? ☐ Type I or ☐ Type II?
- ☐ YES ☐ NO ☐ DK/U Stomach ulcer or hyperacidity?
- ☐ YES ☐ NO ☐ DK/U Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- ☐ YES ☐ NO ☐ DK/U Tires easily?
- ☐ YES ☐ NO ☐ DK/U Birth defects or hereditary problems?
- ☐ YES ☐ NO ☐ DK/U Chest pain, shortness of breath or swelling ankles?
- ☐ YES ☐ NO ☐ DK/U AIDS or HIV positive?
- ☐ YES ☐ NO ☐ DK/U High or low blood pressure?
- ☐ YES ☐ NO ☐ DK/U Cancer, tumor, radiation treatment, or chemotherapy?
- ☐ YES ☐ NO ☐ DK/U Vision, hearing, tasting or speech difficulties?
- ☐ YES ☐ NO ☐ DK/U Hay fever, asthma, sinus trouble?
- ☐ YES ☐ NO ☐ DK/U Skin disorder?
- ☐ YES ☐ NO ☐ DK/U Loss of weight recently, poor appetite?
- ☐ YES ☐ NO ☐ DK/U Eating disorder (anorexia, bulimia)?
- ☐ YES ☐ NO ☐ DK/U Does the patient eat a well-balanced diet?
- ☐ YES ☐ NO ☐ DK/U Cardiovascular problems?
- ☐ YES ☐ NO ☐ DK/U Problems of the immune system?
- ☐ YES ☐ NO ☐ DK/U Polio, mononucleosis, tuberculosis or pneumonia?
- ☐ YES ☐ NO ☐ DK/U Hepatitis, jaundice or liver problems?
- ☐ YES ☐ NO ☐ DK/U Tonsil or adenoid conditions?
- ☐ YES ☐ NO ☐ DK/U Osteoporosis?

Allergies, sensitivities, reactions to the following?

- ☐ YES ☐ NO ☐ DK/U Latex (gloves, balloons)
- ☐ YES ☐ NO ☐ DK/U Metals (jewelry, etc)
- ☐ YES ☐ NO ☐ DK/U Local anesthetics
- ☐ YES ☐ NO ☐ DK/U Acrylic
- ☐ YES ☐ NO ☐ DK/U Other

List all medications, supplements, herbal medications or other non-prescription medicine patient is taking?

_____

_____

_____

- ☐ YES ☐ NO ☐ DK/U Has patient ever taken IV and/or oral medications for bone disorders or cancer (such as bisphosphonates)?
- ☐ YES ☐ NO ☐ DK/U Does patient currently have or ever had a substance abuse problem?
- ☐ YES ☐ NO ☐ DK/U Has or does the patient smoke or chew tobacco?
- ☐ YES ☐ NO ☐ DK/U Operations or hospitalizations?

_____

_____

_____

_____

- ☐ YES ☐ NO ☐ DK/U Other physical problems or symptoms?

_____

_____

- ☐ YES ☐ NO ☐ DK/U Being treated by another healthcare professional?

_____

_____

_____

Please Turn Over and Complete Back

Now or in the past have you had?

- ☐ YES ☐ NO ☐ DK/U Started teething very early or late?
- ☐ YES ☐ NO ☐ DK/U Baby teeth removed that were not loose?
- ☐ YES ☐ NO ☐ DK/U Permanent/extra teeth removed?
- ☐ YES ☐ NO ☐ DK/U Chipped or injured teeth?
- ☐ YES ☐ NO ☐ DK/U Teeth sensitive to hot/cold/sweets?
- ☐ YES ☐ NO ☐ DK/U Root canal treatment?
- ☐ YES ☐ NO ☐ DK/U Gum problems?
- ☐ YES ☐ NO ☐ DK/U Food stuck between teeth?
- ☐ YES ☐ NO ☐ DK/U Frequent canker sores or cold sores?
- ☐ YES ☐ NO ☐ DK/U Thumb, finger, or sucking habit?
- ☐ YES ☐ NO ☐ DK/U Abnormal swallowing habit?
- ☐ YES ☐ NO ☐ DK/U Speech problems?
- ☐ YES ☐ NO ☐ DK/U Mouth breathing habit?
- ☐ YES ☐ NO ☐ DK/U Tooth grinding or clenching?
- ☐ YES ☐ NO ☐ DK/U Pain in jaw or ear area?
- ☐ YES ☐ NO ☐ DK/U Pain/soreness in face muscles?
- ☐ YES ☐ NO ☐ DK/U Difficulty chewing/opening?
- ☐ YES ☐ NO ☐ DK/U Aware of loose crowns/fillings?
- ☐ YES ☐ NO ☐ DK/U Tooth irritation on cheek, tongue, or roof of mouth?
- ☐ YES ☐ NO ☐ DK/U Wisdom tooth problems?
- ☐ YES ☐ NO ☐ DK/U History of underbites in family?
- ☐ YES ☐ NO ☐ DK/U Prior orthodontic evaluation?

When considering orthodontic treatment, what matters to you the most? Please rank in order of importance.

_____ Treatment duration

_____ Aesthetic treatment with Invisalign or clear braces

_____ Cost

- ☐ YES ☐ NO ☐ DK/U Any problems with dental treatment or traumatic dental experiences?
- ☐ YES ☐ NO ☐ DK/U Does the patient follow directions well?
- ☐ YES ☐ NO ☐ DK/U Does the patient brush his/her teeth consistently?
- ☐ YES ☐ NO ☐ DK/U Does the patient have learning disabilities?
- ☐ YES ☐ NO ☐ DK/U Is the patient self-conscious about teeth?
- ☐ YES ☐ NO ☐ DK/U Trauma to face, head or neck?

Female Patients Only:

- ☐ YES ☐ NO ☐ DK/U Are you pregnant?

Adolescent Girls:

- ☐ YES ☐ NO ☐ DK/U Has the patient started monthly periods? If so, when? _____

Other Comments:

_____

_____

_____

_____

_____

_____

Patient or Parent/Guardian Signature: _____ Date:_____

Patient or Parent/Guardian Name (Please Print): _____

Orthodontist Signature: _____ Date:_____

ATLAS 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/10/13 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make healthcare decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Teaching & Educational Purposes: We may use your health information for teaching or educational purposes. We will not disclose your name, address or other personal information, only the clinical aspects of your case.

Public Health Activities: We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;

- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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 the protected health information of an inmate or patient.

Secretary of HHS: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right

to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction: You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a healthcare item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official:
E. Stefan Alexandroni DDS, MS
Telephone: 615-869-7277
Fax: 615-869-7281
Email: info@AtlasBraces.com

Mailing Address:
2863 Old Fort Pkwy, Suite E
Murfreesboro, TN 37128

ATLAS ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

~ YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT ~

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

Print Name: _____

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 (Please Specify)_____