Please respond to all questions

Adult Health History

Drs. Geyer & Binzer, PC

Specialists in Orthodontics

PATIENT'S NAME_____ Prefers to be called "_____" Male ❑ Female ❑

Whom may we thank for referring you to our office?_____ General Dentist_____

Where & When are the best times to reach you? _____

Other family members under age 18 (please list their names & birthdates): _____

Has anyone in the family had braces?_____Who?_____ Were you/they pleased with the results?_____

How often do you see the dentist?_____ Date of last dental exam (Mo./Yr.)_____

What are the main concerns that you would like orthodontics to address?_____

_____

How do you feel about the possibility of wearing orthodontic appliances? _____

Have you been evaluated for or had orthodontic treatment before?	Y	N
Are you self-conscious of your teeth?	Y	N
Have there been any injuries to your face, mouth, teeth or chin?	Y	N
Have you ever been informed of any missing or extra permanent teeth?	Y	N
Have you ever had any pain/discomfort in your jaw joint (TMJ)?	Y	N
Do you have any dental problems at this time (pain, cavities, etc.)?	Y	N
Are you apprehensive about receiving dental care?	Y	N

Have you ever had any of the following **habits**?

Thumb/finger sucking	Y	N	Speech problems	Y	N
Mouth breathing	Y	N	Finger nail biting	Y	N
Clenching/grinding teeth	Y	N	Tongue thrust	Y	N
Smoking	Y	N			

Are you **allergic** to any of the following?

Penicillin	Y	N	Nickel	Y	N
Latex	Y	N	Any other medication	Y	N
Iodine	Y	N	Other Allergies _____		

If any of your answers are 'Y', what happens when you are exposed to the allergen?_____

MEDICAL HISTORY:

Current Physician:_____

Any health problem	Y	N	Ulcers	Y	N
Any hospitilizations	Y	N	Severe headaches	Y	N
Taking any medications	Y	N	Pain of head/face	Y	N
Please list them_____			Diabetes	Y	N
Forceps used during your birth	Y	N	Psychiatric counseling	Y	N
Rheumatic fever, heart disease			Blood transfusions	Y	N
heart murmur	Y	N	Hepatitis	Y	N
Latex Sensitivity	Y	N	Tuberculosis	Y	N
Asthma/respiratory problems	Y	N	AIDS/HIV virus	Y	N
Prolonged bleeding or anemia	Y	N	Mouth/lip lesions (sores)	Y	N
Thyroid or hormone therapy	Y	N	Periodontal Disease	Y	N
Recurrent or chronic illness	Y	N	Epilepsy/seizures	Y	N
			Other infections	Y	N

Please explain any "Y" answers above_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status.

_____ _____

Signature Date

(OVER)

For Office Use Only

TMD HX - WNL CL/POP O-LOCK C-LOCK R L OTHER_____ REC TFR POL EXP_____

DISC._____

A B C

Patient Information

Date_____

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

Responsible Party Information

Name_____ _____ _____
Last First Middle Marital Status E-Mail Address

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address? _____ Rent / Own ? (circle one)

Home Phone_____ Work Phone_____ Cell Phone _____

Previous Address (if less than 3 years)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouses Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Orthodontic Insurance Information

Policy Holder's Name_____ Soc. Sec. or Alternate ID #_____

Insurance Company_____ Group No._____ Policy Holder's B-day_____

Insurance Co. Address_____

Policy Holder's Employer_____

Do you have dual coverage? Yes ❑ No ❑ If yes: Insurance Phone #_____

Policy Holder's Name_____ Soc. Sec. or Alternate ID #_____

Insurance Company_____ Group No._____ Policy Holder's B-day_____

Insurance Co. Address_____

Policy Holder's Employer_____ Insurance Phone #_____

Emergency Information

Name of nearest relative not living with you_____

Complete address_____

Home Phone_____ Work Phone_____ Cell Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parents signature if minor)_____

Updates (date & initial)_____ _____ _____ _____

CONFIDENTIAL (for record and pretreatment evaluation)

Drs. Geyer & Binzer, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit our office, we make a record of your visit in order to manage the care you receive. We understand that the medical information that is recorded about you and your health is personal. The confidentiality and privacy of your health information is also protected under both state and federal law. This Notice of Privacy Practices describes how this office may use and disclose your information and the rights that you have regarding your health information.

How We Will Use or Disclose Your Health Information

Treatment: We will use your health information for treatment. For example, information obtained by the orthodontist or other members of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your orthodontist will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations, so the physician will know how you are responding to treatment. We will also provide your physician, or a subsequent healthcare provider, with copies of various reports that should assist him or her in treating you.

Payment: We will use your health information for payment. For example, a bill may be sent to you or your health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Health Care Operations: We will use your health information for our regular health care operations. For example, we may use information in your health record to assess the care and outcome in your case and others like it. This information will then be used in a continued effort to improve the quality and effectiveness of the services we provide.

Business Associates: We may enter into contracts with persons or entities known as business associates that provide services to or perform functions on our behalf. Examples include our accountants, consultants, and attorneys. We may disclose your health information to our business associates so they can perform the job we have asked them to do, once they have agreed in writing to safeguard your information.

Notification: We may use or disclose information to assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided to us, e.g., on an answering machine.

Communication with Family: We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Appointment Reminders / Health Benefits: We may contact you to provide appointment reminders or information about treatment alternatives or other health benefits that may be of interest to you.

Funeral Directors and Coroners: We may disclose your health information to funeral directors, and to coroners or medical examiners, to carry out their duties consistent with applicable law.

Organ Procurement Organizations: Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Research: We may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may also disclose your health information to people preparing to conduct a research project, so long as the health information is not removed from us. We may also use and disclose your health information to contact you about the possibility of enrolling in a research study.

Fundraising: We may contact you as part of our fundraising efforts; however, you may opt-out of receiving such communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs established by law.

Public Health Activities: As required by law, we may disclose your health information to public health, or legal authorities, charged with preventing or controlling disease, injury, or disability.

Health Oversight Activities: We may disclose your health information to health oversight agencies for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution, or agents thereof, health information necessary for your health and the health and safety of other individuals.

Judicial and Administrative Proceedings: We may disclose your health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.

Law Enforcement Purposes / Serious Threat to Health or Safety: We may disclose your health information to enforcement officials for law enforcement purposes under certain circumstances and subject to certain conditions. We may also disclose your health information to prevent or lessen a serious and imminent threat to a person or the public (when the disclosure is made to someone we believe can prevent or lessen the threat) or to identify or apprehend an escapee or violent criminal.

Victims of Abuse. Neglect. and Domestic Violence: In certain circumstances, we may disclose your health information to appropriate government authorities if there are allegations of abuse, neglect, or domestic violence.

Essential Government Functions: We may disclose your health information for certain essential government functions (e.g., military activity and for national security purposes).

The following uses and disclosures will be made only with your authorization: (i) with limited exceptions, uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in this notice. You may revoke your authorization at any time in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

Your Health Information Rights

Although your health record is the physical property of this office, you have the following rights with respect to your health information:

You may request that we not use or disclose your health information for a particular reason related to treatment, payment, our general healthcare operations, and/or to a particular family member, other relatives or close personal friend. We ask that such requests be made in writing on a form provided by us. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it, except as provided below.

If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We ask that such requests be made in writing on a form provided by us. We are required to abide by such a request, except where we are required by law to make a disclosure. We are not required to inform other providers of such a request, so you should notify any other providers regarding such a request.

You have the right to receive confidential communications from us by alternative means or at an alternative location. Such a request must be made in writing, and submitted to the Privacy Officer. We will attempt to accommodate all reasonable requests.

You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If we maintain your health information electronically in a designated record set, you may obtain an electronic copy of the information. If you request a copy (paper or electronic), we will charge you a reasonable, cost-based fee.

If you believe that any health information in your record is incorrect, or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by us to make such requests. For a request form, please contact the Privacy Officer.

You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed six years), as required by law. We ask that such requests be made in writing on a form provided by us. Please note that accounting does not include all disclosures, e.g., disclosures to carry out treatment, payment, or healthcare operations and disclosures made to you or your legal representative or pursuant to an authorization. You will not be charged for your first accounting request in any 12-month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee.

You have the right to be notified following a breach of your unsecured protected health information. You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

For More Information or to Report a Problem

You have the right to complain to us and to the Secretary of the U.S. Department of Health and Human Services (HHS) if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

For more information or to file a complaint with us, contact:

Dr. Curtis K. Geyer or Dr. Randall H. Binzer
Address: P.O. Box 1457 Spencer, IA 51301 Telephone: 712-262-4716
Fax: 712-262-5957

To file a complaint with the Secretary of 1--11-IS, send your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
601 East 12th Street - Room 353
Kansas City, MO 64106
Voice Phone (800) 368-1019
FAX (816) 426-3686

If you have any questions or want more information about this Notice of Privacy Practices, please contact our Privacy Officer.

Acknowledged _____ By:Date: _____
Signature of Patient or Personal Representative

Updated 10/20/2013