

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

Doctor: **S** **P** **T** **L**

Location: **J** **F** **M** **P** **B** **NL**

Exam With: \_\_\_\_\_

## New Patient Information

Patient Name: \_\_\_\_\_ Male  Female  DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Hobbies/Special Interests: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Cell Phone Carrier (i.e. Verizon, AT&T): \_\_\_\_\_

Email: \_\_\_\_\_ SSN: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of Other Family Members Treated at Associated Orthodontists: \_\_\_\_\_

Who Referred You To Associated Orthodontists? \_\_\_\_\_

## Father's Information (for minor patients)

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

Birthday: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_\_  
MM DD YYYY

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

City/State/Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Cell Phone Carrier (i.e. Verizon, AT&T): \_\_\_\_\_

Employer: \_\_\_\_\_

Marital Status:

Single  Married  Separated  Divorced  Widowed

Domestic Partner  Other: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

## Mother's Information (for minor patients)

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

Birthday: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_\_  
MM DD YYYY

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

City/State/Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Cell Phone Carrier (i.e. Verizon, AT&T): \_\_\_\_\_

Employer: \_\_\_\_\_

Marital Status:

Single  Married  Separated  Divorced  Widowed

Domestic Partner  Other: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

## Additional Responsible Party Information - If Applicable (i.e. Stepparent, Legal Guardian)

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

Birthday: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Cell Phone Carrier (i.e. Verizon, AT&T): \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status:

Single  Married  Separated  Divorced  Widowed  Domestic Partner  Other: \_\_\_\_\_

By providing the phone number(s) above, I expressly consent to receiving telephone calls and/or text messages from the Practice and its agents and representatives via an automatic telephone dialing system, other computer-assisted technology, or pre-recorded message(s), for any purpose, including, but not limited to, appointment and follow-up health care reminders, scheduling, patient account(s), assignment of benefits, and/or financial responsibility. I understand that, depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change.



# New Patient Information

---

## Dentist Practice Information

Practice Name: \_\_\_\_\_ Dentist Name: \_\_\_\_\_

Location of Office: \_\_\_\_\_

Date of Last Cleaning: \_\_\_\_\_

Is There Pending Treatment:  Yes  No

If yes, please Explain: \_\_\_\_\_

---

## Health History Information

Please check all that apply below. If NONE check here

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abnormal Bleeding      | <input type="checkbox"/> Tonsils and/or Adenoids Removed<br>Date: _____ | <input type="checkbox"/> Hi/Low Blood Pressure   |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Allergies to Any Drugs                         | <input type="checkbox"/> Mitral Valve Prolapse   |
| <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Diabetes                                       | <input type="checkbox"/> Finger Sucking          |
| <input type="checkbox"/> Hemophilia             | <input type="checkbox"/> Hearing Impaired                               | <input type="checkbox"/> Heart Murmur            |
| <input type="checkbox"/> Jaw Clicking           | <input type="checkbox"/> Hepatitis A, B or C                            | <input type="checkbox"/> HIV Positive/AIDS       |
| <input type="checkbox"/> TMJ                    | <input type="checkbox"/> Kidney/Liver Problems                          | <input type="checkbox"/> Latex Allergies         |
| <input type="checkbox"/> Metal Allergies        | <input type="checkbox"/> Pregnant                                       | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Scarlet Fever          | <input type="checkbox"/> Smoking/Tobacco                                | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Difficulty Breathing   | <input type="checkbox"/> Anorexia/Bulimia                               | <input type="checkbox"/> ADD or ADHD             |

Have you ever taken any medications for osteoporosis?  Yes  No

Please list current medications: \_\_\_\_\_

Please list any known drug allergies: \_\_\_\_\_

Please discuss any surgeries or serious medical concerns the child has had: \_\_\_\_\_

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

---

# New Patient Information

---

## Authorization for Release of Patient Information and Use of Records ("Authorization")

I authorize the release of information in the patient's record regarding the patient's treatment, and/or financial obligations related to the patient's treatment, to the parties listed below. I understand that once personal health and/or financial information is disclosed as per this Authorization, the Practice has no responsibility for any further release by the individual receiving the patient's information.

I understand that I may refuse to sign this Authorization and that my refusal to sign this Authorization will neither affect nor limit the patient's ability to obtain treatment or affect any payment, enrollment, or eligibility for benefits.

I understand that I may revoke this Authorization by sending written notification to the Practice's Privacy Officer at the address set forth below; provided, however, that my notice to revoke this Authorization will not apply to actions taken in reliance on this Authorization prior to the date my written notice is received by the Practice's Privacy Officer.

Associated Orthodontists  
Dana E. Fender DMD, PC  
Attn: Privacy Officer  
295 SE Inner Loop  
Georgetown, TX 78626

This Authorization shall expire upon the earlier of: (i) the termination of the patient's treatment with the Practice; or (ii) my express written revocation of this Authorization with regard to a recipient. In each case, my historic authorization will remain effective as to protected health information that was disclosed prior to expiration/revocation of this Authorization.

I have read and understand the information contained within this Authorization and selected the applicable responses to indicate my agreement and to allow the use and disclosure of my /the patient's medical and/or financial record information as described above.

- |                          |                           |                         |
|--------------------------|---------------------------|-------------------------|
| <input type="checkbox"/> | _____                     | _____                   |
|                          | Name of Authorized Person | Relationship to Patient |
| <input type="checkbox"/> | _____                     | _____                   |
|                          | Name of Authorized Person | Relationship to Patient |
| <input type="checkbox"/> | _____                     | _____                   |
|                          | Name of Authorized Person | Relationship to Patient |

---

Signature of Patient/Responsible Party

Date

# New Patient Information

---

## Patient/Authorized Representative Authorization for Release of Certain Protected Health Information

By signing this authorization ("Authorization"), I hereby agree as follows:

1. I grant Dana E. Fender DMD,PC ("Practice"), acting through the Practice's employees, agents, contractors, or business associates, the right to use, disclose, and publish certain protected health information ("PHI"), including but not limited to my name, biographical information, voice, photograph, video, and/or likeness, including that which is contained within or related to any patient testimonial, including any such testimonial that I may post on social media or review websites (collectively, the "Information"), for the purposes of marketing, public relations, professional consultations, research, education, or publication in professional journals. Any such Information disclosure made by the Practice may be made available to the general public through the posting of the Information on the Practice's websites, social media pages, and through printed advertisements, television, radio announcements, and other promotional publications of the Practice.
2. I understand that the Practice may use the Information for the purposes outlined in this document and that this may benefit the Practice. I further understand that the Practice does not, and will not ever, owe me any royalty or other amount relating to use of the Information.
3. I understand that I have no right to inspect or approve of any printed or electronic matter that may be used as described herein and that the matter and materials in which my Information is used may be modified, edited, or combined with other materials. I further understand and agree that the Practice will retain the exclusive right to approve or disapprove of the extent, format, and manner in which my Information may be released. I understand and agree that the Practice will not be liable for any publication or broadcast errors.
4. I understand that entering into this Authorization is voluntary, that I may refuse to sign this Authorization, and that the Practice will not condition the commencement or continuation of treatment on my decision as to whether to provide this Authorization, nor would my refusal to sign this Authorization affect any payment, enrollment or eligibility for benefits from any source. I further understand that I may revoke this Authorization at any time after signing it by providing written notice that I would like to revoke this Authorization to the Practice at:

Associated Orthodontists  
Dana E. Fender DMD, PC  
Attention: Privacy Officer  
295 SE Inner Loop  
Georgetown, TX 78626

5. I understand that my grant of rights to the Practice contained in this Authorization cannot be revoked to the extent that action has already been taken in reliance on this Authorization prior to the date that the Practice receives my written request to revoke this Authorization. This Authorization shall expire ten (10) years from the date of my signature unless I terminate my grant of rights to the Practice contained herein earlier. Such termination of rights shall be on a prospective basis from and after the day on which my revocation is received by the Privacy Officer noted above .
6. I understand that the Practice will not use or disclose my PHI for the reasons set forth herein beyond the scope of this Authorization without my written consent/authorization or as otherwise permitted or required by applicable law. I further understand that disclosed Information may be subject to re-disclosure by the recipient, including any member of the public, and any such re-disclosure shall not require additional consent on my part.
7. I hereby waive, authorize, discharge and agree to hold harmless the Practice and its employees, agents, contractors, or business associates and their respective officers, directors, employees, agents, successors, and assigns and anyone authorized by any of them from any and all losses, damages, costs, expenses, rights, claims, demands, liability and actions, that may result from any use of the Information, including any distortion of my likeness, that may occur in the taking, processing, reproduction, publication or distribution of my Information, including without limitation from any claim for libel, slander, defamation, invasion of right privacy/publicity, false light or any other claim arising from or relating to the exercise of rights granted hereunder.
8. If this Authorization is signed by the authorized representative of the patient and/or dependent child, the terms "I," "me," and "my," shall be interpreted to apply to the patient, as applicable.

## New Patient Information

---

By signing below, I authorize the use or disclosure of the Information, including PHI, as described above, and acknowledge that I have read and accept all of the terms set forth in the Authorization.

All of my questions about this Authorization have been answered in full.

---

Signature of Patient or Patient's Authorized Representative

---

Print Name

---

Relationship (if signed by person other than patient)

---

Date

# Notice of Privacy Practices

---

**THIS NOTICE OF PRIVACY PRACTICES (“NOTICE”) DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

The privacy of your protected health information (“PHI”) is important to us. Your Smile Doctors practice (the “Practice”) is required by law to: (i) maintain the privacy of PHI; (ii) provide individuals with notice of the Practice’s legal duties and privacy practices with respect to PHI; (iii) notify affected individuals following a breach of unsecured PHI; and (iv) follow the terms of the Notice that is currently in effect. This Notice will remain in effect until the Practice replaces it.

The Practice reserves the right to change its 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 PHI that the Practice maintains. When the Practice makes a significant change in its privacy practices, it will change this Notice and post the new Notice clearly and prominently at its practice location and on the Smile Doctors LLC website. Further, the Practice will provide copies of the new Notice upon request.

You may request a copy of the Practice’s Notice at any time. For more information about the Practice’s privacy practices, or for additional copies of this Notice, please contact Dr. Greg Goggans, Privacy Officer, using the information listed at the end of this Notice.

## **HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PHI**

The Practice may use and disclose your PHI for different purposes, including but not limited to treatment, payment, and health care operations. For each of these categories, the Practice has provided a description and an example below. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records, if applicable, may be entitled to special confidentiality protections under applicable state or federal law. The Practice will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** The Practice may use and disclose your PHI for treatment purposes. For example, the Practice may disclose your PHI to a physician/dentist, dental auxiliaries, or other healthcare providers providing treatment to you.

**Payment.** The Practice may use and disclose your PHI to obtain reimbursement for the treatment and services you receive from the Practice. Payment activities include but are not limited to billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, the Practice may send claims to your health plan containing certain PHI.

**Healthcare Operations.** The Practice may use and disclose your PHI in connection with its healthcare operations. Healthcare operations include but are not limited to quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performances, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Individuals Involved in Your Care or Payment for Your Care.** The Practice may disclose your PHI to a family member, other relative, close personal friend, or any other individual identified by you relative to that person’s involvement in your care or in the payment for your care. In the event of your absence or incapacity or in emergency circumstances, the Practice may, based on a determination in its providers’ professional judgment, disclose certain of your PHI that is directly relevant to such person’s involvement in your healthcare and treatment. Additionally, the Practice may disclose information about you to your personal representative. If a person has the authority by law to make health care decisions for you, the Practice will treat that personal representative the same way it would treat you with respect to your PHI.

**Appointment Reminders.** The Practice may use or disclose your PHI to provide you with appointment reminders (such as voicemail messages, text messages, emails, postcards, or letters).

# Notice of Privacy Practices

---

**Disaster Relief.** The Practice may use or disclose your PHI to assist in disaster relief efforts.

**Required by Law.** The Practice may use or disclose your PHI when it is required to do so by law.

**Public Health Activities.** The Practice may disclose your PHI for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report potential abuse, neglect, or domestic violence;
- 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

**National Security.** The Practice may disclose to military authorities the PHI of armed forces personnel under certain circumstances. The Practice may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. The Practice may disclose PHI to a correctional institution or law enforcement official that or who has lawful custody of the patient.

**Secretary of HHS.** The Practice will disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA or other federal laws.

**Worker's Compensation.** The Practice may disclose your PHI 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.

**Law Enforcement.** The Practice may disclose your PHI for law enforcement purposes as permitted and authorized under HIPAA or other applicable law. These oversight activities include but are not limited to audits, investigations, inspections, and credentialing, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** The Practice may disclose your PHI to an oversight agency for activities 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, the Practice may disclose your PHI in response to a court or administrative order. The Practice may also disclose PHI 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 the Practice, to tell you about the request or to obtain an order protecting the information requested.

**Research.** The Practice may disclose information 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 PHI.

**Coroners, Medical Examiners, and Funeral Directors.** The Practice 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. The Practice may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**To Avert a Serious Threat to Health or Safety.** The Practice may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

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

# Notice of Privacy Practices

---

**Business Associate.** Some of the Practice's activities are provided on its behalf through contracts with business associates. When the Practice enters into contracts to obtain these services, the Practice may need to disclose your PHI to a business associate so that the business associate may perform the job for which the Practice has contracted; however, the Practice requires its business associates to appropriately safeguard your PHI.

## OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with limited exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. The Practice 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, the Practice will stop using or disclosing your PHI, except to the extent that it has already taken action in reliance on the authorization or as required under applicable law.

## YOUR HEALTH INFORMATION RIGHTS

**Access.** You have the right to view or obtain copies of your PHI and other treatment 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 the Privacy Officer a message to the email address set forth at the end of this Notice. If you request information that the Practice maintains on paper, the Practice may provide photocopies. If you request information that the Practice maintains electronically, you have the right to an electronic copy. The Practice will use the form and format that you request if readily producible. The Practice 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 the Privacy Officer using the information listed at the end of this Notice for an explanation of the Practice's 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 PHI in accordance with applicable laws and regulations, with such disclosures being available for the 6 years prior to the date of such request. To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer. If you request this accounting more than once in a 12-month period, the Practice 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 the Practice's use or disclosure of your PHI by submitting a written request to the Privacy Officer. Your written request must include (i) what information you want to limit, (ii) whether you want to limit the Practice's use, disclosure, or both, and (iii) to whom you want the limits to apply. The Practice is 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 health care item or service for which you, or a person on your behalf (other than the health plan), has paid the Practice in full.

**Alternative Communication.** You have the right to request that the Practice communicates with you about your PHI 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. The Practice will accommodate all reasonable requests; however, if the Practice is unable to contact you using the methods or locations you have subsequently requested, then the Practice may contact you using any information that it has available.

**Amendment.** You have the right to request that the Practice amend your PHI. Your request to amend must be in writing, and it must explain why you believe your information should be amended. If the Practice agrees to your request, it will amend your record(s) and notify you of such amendment. However, the Practice may deny your

# Notice of Privacy Practices

---

request to amend under certain circumstances. If the Practice denies your request for amendment, it will provide you with a written explanation regarding the reason for denial and will further explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured PHI 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 the Practice's website or by electronic mail (e-mail).

**Questions and Complaints.** If you would like more information about the Practice's privacy practices or have questions or concerns, please contact the Privacy Officer using the contact information set forth at the end of this Notice.

If you: (i) are concerned that the Practice may have violated your privacy rights, (ii) disagree with a decision the Practice made about (a) access to your PHI or (b) in response to a request you made to amend or restrict the use or disclosure of your PHI, or (iii) would like to have the Practice communicate with you by alternative means or at alternative locations, you may communicate as such to the Privacy Officer using the contact information listed at the end of this Notice. You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services. The Privacy Officer will provide you with the address to file a complaint with the U.S. Department of Health and Human Services upon request.

The Practice supports your right to the privacy of your PHI. The Practice will not retaliate in any way if you choose to file a complaint with the Practice or with the U.S. Department of Health and Human Services.

**Our Privacy Officer:** Dr. Greg Goggans

**Telephone:** 1 (877) 221-9008

**Email Address:** [hipaa.privacy@smiledoctors.com](mailto:hipaa.privacy@smiledoctors.com)

\* \* \* \* \*

I hereby acknowledge that I have reviewed and received a copy of the Notice of Privacy Practices.

Patient/Patient Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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