ORTHODONTIC Specialists of Florida

# Medical Dental History Form For Adult Patients

***WELCOME TO OUR PRACTICE! HOW DID YOU HEAR ABOUT US?*** _____

## PATIENT

Date _____ Sex ◯Male ◯Female Age _____

Patient's Last Name _____ First Name _____ MI _____

Title ◯Mr. ◯Mrs. ◯Ms/Miss ◯Dr. ◯Other Prefers to be called _____

Birth Date _____ Social Security # _____ - _____ - _____

Marital Status ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯Widowed

E-mail address(es) _____

Home address _____

City, State, Zip Code _____

Home/Cell phone (_____)_____-_____ Work phone (_____)_____-_____

Family members previously treated with us _____

_____

## CLOSEST RELATIVE

Spouse or Closest relative's name(s)_____

Title ◯ Mr. ◯Mrs. ◯Ms. ◯Miss ◯Dr. ◯Other

Relationship to patient _____

Marital Status ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯Widowed

Email Address(es)_____

Home address (if different)_____

City, State, Zip Code _____

Cell phone (_____)_____-_____ Work phone (_____)_____-_____

Occupation _____

Employer _____

## PRIMARY DENTAL INSURANCE

Policy Holder's Full Name_____

Birth Date _____ SSN/ID# _____

Insurance Company Name _____

Phone (_____)_____-_____ Group Name _____

Gender ◯ Male ◯ Female Relationship to Patient_____

Employment Status ◯ Full Time ◯ Part Time ◯Retired ◯Student

Marital Status_____ Orthodontic Benefits ◯Yes ◯No

## EMPLOYMENT INFORMATION

Employer _____

Address _____

City, State, Zip Code _____

Work E-mail address(es) _____

Work phone (_____)_____-_____

Employment Status ◯ Full Time ◯Part Time ◯ Retired ◯ Student

## SECONDARY DENTAL INSURANCE

Policy Holder's Full Name_____

Birth Date _____ SSN/ID# _____

Insurance Company Name _____

Phone (_____)_____-_____ Group Name _____

Gender ◯ Male ◯ Female Relationship to Patient_____

Employment Status ◯ Full Time ◯ Part Time ◯ Retired ◯ Student

Marital Status_____ Orthodontic Benefits ◯Yes ◯ No

## DENTIST

Patient's Dentist _____

Last Seen _____ Reason _____ Next Appt _____

Has all of the patient's dental work been completed ◯Yes ◯ No _____

Address _____

City, State, Zip Code _____

Other dentists/dental specialists now being seen _____

Reason _____

## MEDICAL INSURANCE

Medical Insurance- Policy Holder's Full Name _____

Insurance Company _____

Phone (____)_____-_____ Group Name _____

Gender ◯ Male ◯ Female Relationship to Patient _____

## PHYSICIAN

Patient's Physician _____

Last Seen _____ Reason _____ Next Appt _____

Other Physicians/Health Care Providers being seen now _____

Reason _____

## GENERAL INFORMATION

What concerns you about your teeth? _____

Have you had any previous orthodontic treatment? Please describe_____

_____

Describe any previous orthodontic treatment or consultations. _____

_____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

_____

**Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.** ***For the following questions, please mark yes, no, or don't know/understand (dk/u).***

**MEDICAL HISTORY**

**Now or in the past, have you had:**

yes◯ no◯ dk/u◯ Birth defects or hereditary problems?
yes◯ no◯ dk/u◯ Bone fractures, or major injuries?
yes◯ no◯ dk/u◯ Any injuries to face, head, neck?
yes◯ no◯ dk/u◯ Arthritis or joint problems?
yes◯ no◯ dk/u◯ Cancer, tumor, radiation treatment or chemotherapy?
yes◯ no◯ dk/u◯ Endocrine or thyroid problems?
yes◯ no◯ dk/u◯ Diabetes or low sugar?
yes◯ no◯ dk/u◯ Kidney problems?
yes◯ no◯ dk/u◯ Immune system problems?
yes◯ no◯ dk/u◯ History of osteoporosis?
yes◯ no◯ dk/u◯ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
yes◯ no◯ dk/u◯ AIDS or HIV positive?
yes◯ no◯ dk/u◯ Hepatitis, jaundice or liver problems?
yes◯ no◯ dk/u◯ Polio, mononucleosis, tuberculosis, pneumonia?
yes◯ no◯ dk/u◯ Seizures, Fainting spells, neurological problem?
yes◯ no◯ dk/u◯ Mental health disturbance or depression?
yes◯ no◯ dk/u◯ History of eating disorder (anorexia, bulimia)?
yes◯ no◯ dk/u◯ Frequent headaches or migraines?
yes◯ no◯ dk/u◯ High or low blood pressure?
yes◯ no◯ dk/u◯ Excessive bleeding or bruising tendency, anemia?
yes◯ no◯ dk/u◯ Chest pain, shortness of breath, tire easily, swollen ankles?
yes◯ no◯ dk/u◯ Heart defects, heart murmur, rheumatic heart disease?
yes◯ no◯ dk/u◯ Angina, arteriosclerosis, stroke or heart attack?
yes◯ no◯ dk/u◯ Skin disorder (other than common acne)?
yes◯ no◯ dk/u◯ Do you eat a well-balanced diet?
yes◯ no◯ dk/u◯ Vision, hearing, or speech problems?
yes◯ no◯ dk/u◯ Frequent ear infections, colds, throat infections?
yes◯ no◯ dk/u◯ Asthma, sinus problems, hay fever?
yes◯ no◯ dk/u◯ Tonsil or adenoid condition?
yes◯ no◯ dk/u◯ Do you frequently breathe through your mouth?
yes◯ no◯ dk/u◯ Have you ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
yes◯ no◯ dk/u◯ Have you ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?
yes◯ no◯ dk/u◯ Other, please describe _____
_____

**Have you had allergies or reactions to any of the following?:**

yes◯ no◯ dk/u◯ Local anesthetics (novocaine, lidocaine, xylocaine)
yes◯ no◯ dk/u◯ Latex (gloves, balloons)
yes◯ no◯ dk/u◯ Aspirin
yes◯ no◯ dk/u◯ Ibuprofen (Motrin, Advil)
yes◯ no◯ dk/u◯ Penicillin
yes◯ no◯ dk/u◯ Other antibiotics
yes◯ no◯ dk/u◯ Sulfa drugs
yes◯ no◯ dk/u◯ Codeine or other narcotics
yes◯ no◯ dk/u◯ Metals (jewelry, clothing snaps)
yes◯ no◯ dk/u◯ Acrylics
yes◯ no◯ dk/u◯ Plant pollens
yes◯ no◯ dk/u◯ Animals
yes◯ no◯ dk/u◯ Foods (specify) _____
yes◯ no◯ dk/u◯ Other substances (specify) _____

**DENTAL HISTORY**

**Now or in the past, have you had:**

yes◯ no◯ dk/u◯ Erupting teeth very early or late?
yes◯ no◯ dk/u◯ Primary (baby) teeth removed that were not loose?
yes◯ no◯ dk/u◯ Permanent or "extra" (supernumerary) teeth removed?
yes◯ no◯ dk/u◯ Supernumerary (extra) or congenitally missing teeth?
yes◯ no◯ dk/u◯ Chipped or injured primary or permanent teeth?
yes◯ no◯ dk/u◯ Any sensitive or sore teeth?
yes◯ no◯ dk/u◯ Any lost or broken fillings?
yes◯ no◯ dk/u◯ Jaw fractures, cysts, infections?
yes◯ no◯ dk/u◯ Any teeth treated with root canals or pulpotomies?
yes◯ no◯ dk/u◯ Frequent canker sores or cold sores?
yes◯ no◯ dk/u◯ History of speech problems or speech therapy?
yes◯ no◯ dk/u◯ Difficulty breathing through nose?
yes◯ no◯ dk/u◯ Mouth breathing habit or snoring at night?
yes◯ no◯ dk/u◯ Frequent oral habits (sucking finger, chewing pen, nail biting, etc.)?
yes◯ no◯ dk/u◯ Teeth causing irritation to lip, cheek or gums?
yes◯ no◯ dk/u◯ Tooth grinding or clenching?
yes◯ no◯ dk/u◯ Clicking, locking in jaw joints?
yes◯ no◯ dk/u◯ Soreness in jaw muscles or face muscles?
yes◯ no◯ dk/u◯ Have you ever been treated for "TMJ" or "TMD" problems?
yes◯ no◯ dk/u◯ Any serious trouble associated with any previous dental treatment?
yes◯ no◯ dk/u◯ Have you ever been diagnosed with gum disease or pyorrhea or had periodontal (gum) treatment?

## PATIENT HEALTH INFORMATION

Do you think any of your activities affect your face, teeth or jaws? How?_____
List any medication, nutritional supplements, herbal medications, or non-prescription medicines, including fluoride supplements that you take_____
_____

Do you currently have (or ever had) a substance abuse problem? yes◯ no◯ Do you chew or smoke tobacco? yes◯ no◯
Have you noticed any unusual changes in your face or jaws? yes◯ no◯ Any other physical problems? yes◯ no◯ _____
Women: Are you pregnant? yes◯ no◯ Are you trying to become pregnant? yes◯ no◯

## FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.
◯Bleeding disorders ◯Diabetes ◯Arthritis ◯Severe Allergies ◯Unusual dental problems ◯Jaw size imbalance ◯ Other family medical conditions

_____

How often do you brush?_____ Floss? _____

## RELEASE AND WAIVER

**I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.**

**PATIENT SIGNATURE _____ DATE _____**

**I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.**
**PATIENT SIGNATURE _____ DATE _____**

**I have reviewed the medical/dental information above with the patient name herein. Doctor Initials _____ Date _____**

**Doctor's Comments** _____

## MEDICAL HISTORY UPDATES

| | |
|---|---|
| Changes? _____ | Changes? _____ |
| Patient Signature _____ Date _____ | Patient Signature _____ Date _____ |
| Dental Staff Signature _____ Date _____ | Dental Staff Signature _____ Date _____ |

ORTHODONTIC
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# INFORMED CONSENT

**Patient Name:**_____ **Date:**_____

**Results of Treatment**
Orthodontic treatment usually proceeds as planned, and we intend to do everything possible to achieve the best results for every patient. However, we cannot guarantee that you will be completely satisfied with your results, nor can all complication or consequences be anticipated. The success of treatment depends on your cooperation in keeping appointments, maintaining good oral hygiene, avoiding loose or broken appliances, and following the orthodontist's instructions carefully..

**Length of Treatment**
The length of treatment depends on a number of issues, including the severity of the problem, the patient's growth and the level of patient cooperation. The actual treatment time is usually close to the estimated treatment time, but treatment may be lengthened if, for example, unanticipated growth occurs, if there are habits affecting the dentofacial structures, if periodontal or other dental problems occur, or if patient cooperation is not adequate. Therefore changes in the original treatment plan may become necessary. If treatment time is extended beyond the original estimate, additional fees may be assessed.

**Discomfort**
The mouth is very sensitive so you can expect an adjustment period and some discomfort due to the introduction of orthodontic appliances. Nonprescription pain medication can be used during this adjustment period.

**Relapse**
Completed orthodontic treatment does not guarantee perfectly straight teeth for the rest of your life. Retainers will be required to keep your teeth in their new positions as a result of your orthodontic treatment. You must wear your retainers as instructed or teeth may shift, in addition to other adverse effects. Regular retainer wear is often necessary for several years following orthodontic treatment. However, changes after that time can occur due to natural causes, including habits such as tongue thrusting, mouth breathing, and growth and maturation that continue throughout life. Later in life, most people will see their teeth shift. Minor irregularities, particularly in the lower front teeth, may have to be accepted. Some changes may require additional orthodontic treatment or, in some cases, surgery. Some situations may require non-removable retainers or other dental appliances made by your family dentist.

**Extractions**
Some cases will require the removal of deciduous (baby) teeth or permanent teeth. There are additional risks associated with the removal of teeth which you should discuss with your family dentist or oral surgeon prior to the procedure.

**Orthognathic Surgery**
Some patients have significant skeletal disharmonies which require orthodontic treatment in conjunction with orthognathic (dentofacial) surgery. There are additional risks associated with this surgery which you should discuss with your oral and/or maxillofacial surgeon prior to beginning orthodontic treatment. Please be aware that orthodontic treatment prior to orthognathic surgery often only aligns the teeth within the individual dental arches. Therefore, patients discontinuing orthodontic treatment without completing the planned surgical procedures may have a malocclusion that is worse than when they began treatment!

**Decalcification and Dental Caries**
Excellent oral hygiene is essential during orthodontic treatment as are regular visits to your family dentist. Inadequate or improper hygiene could result in cavities, discolored teeth, periodontal disease and/or decalcification. These same problems can occur without orthodontic treatment, but the risk is greater to an individual wearing braces or other appliances. These problems may be aggravated if the patient has not had the benefit of fluoridated water or its substitute, or if the patient consumes sweetened beverages or foods.

**Root Resorption**
The roots of some patients' teeth become shorter (resorption) during orthodontic treatment. It is not known exactly what causes root resorption, nor is it possible to predict which patients will experience it. However, many patients have retained teeth throughout life with severely shortened roots. If resorption is detected during orthodontic treatment, your orthodontist may recommend a pause in treatment or the removal of the appliances prior to the completion of orthodontic treatment.

**Nerve Damage**
A tooth that has been traumatized by an accident or deep decay may have experienced damage to the nerve of the tooth. Orthodontic tooth movement may, in some cases, aggravate this condition. In some cases, root canal treatment may be necessary. In severe cases, the tooth or teeth may be lost.

**Periodontal Disease**
Periodontal (gum and bone) disease can develop or worsen during orthodontic treatment due to many factors, but most often due to the lack of adequate oral hygiene. You must have your general dentist, or if indicated, a periodontist monitor your periodontal health during orthodontic treatment every three to six months. If periodontal problems cannot be controlled, orthodontic treatment may have to be discontinued prior to completion.

**Injury from Orthodontic Appliances**
Activities or foods which could damage, loosen or dislodge orthodontic appliances need to be avoided. Loosened or damaged orthodontic appliances can be inhaled or swallowed or could cause other damage to the patient. You should inform your orthodontist of any unusual symptoms or of any loose or broken appliances as soon as they are noticed. Damage to the enamel of a tooth or to a restoration (crown, bonding, veneer, etc.) is possible when orthodontic appliances are removed. This problem may be more likely when esthetic (clear or tooth colored) appliances have been selected. If damage to a tooth or restoration occurs, restoration of the involved tooth/teeth by your dentist may be necessary.

**Headgears**
Orthodontic headgears can cause injury to the patient. Injuries can include damage to the face or eyes. In the event of injury or especially an eye injury, however minor, immediate medical help should be sought. Refrain from wearing headgear in situations where there may be a chance that it could be dislodged or pulled off. Sports activities and games should be avoided when wearing orthodontic headgear..

**Temporomandibular (Jaw) Joint Dysfunction**
Problems may occur in the jaw joints, i.e., temporomandibular joints (TMJ), causing pain, headaches or ear problems. Many factors can affect the health of the jaw joints, including past trauma (blows to the head or face), arthritis, hereditary tendency to jaw joint problems, excessive tooth grinding or clenching, poorly balanced bite, and many medical conditions. Jaw joint problems may occur with or without orthodontic treatment. Any jaw joint symptoms, including pain, jaw popping or difficulty opening or closing, should be promptly reported to the orthodontist. Treatment by other medical or dental specialists may be necessary.

**Impacted, Ankylosed, Unerupted Teeth**
Teeth may become impacted (trapped below the bone or gums), ankylosed (fused to the bone) or just fail to erupt. Oftentimes, these conditions occur for no apparent reason and generally cannot be anticipated. Treatment of these conditions depends on the particular circumstance and the overall importance of the involved tooth, and may require extraction, surgical exposure, surgical transplantation or prosthetic replacement.

**Occlusal Adjustment**
You can expect minimal imperfections in the way your teeth meet following the end of treatment. An occlusal equilibration procedure may be necessary, which is a grinding method used to fine-tune the occlusion. It may also be necessary to remove a small amount of enamel in between the teeth, thereby "flattening" surfaces in order to reduce the possibility of a relapse.

**Non-Ideal Results**
Due to the wide variation in the size and shape of the teeth, missing teeth, etc., achievement of an ideal result (for example, complete closure of a space) may not be possible. Restorative dental treatment, such as esthetic bonding, crowns or bridges or periodontal therapy, may be indicated. You are encouraged to ask your orthodontist and family dentist about adjunctive care.

**Third Molars**
As third molars (wisdom teeth) develop, your teeth may change alignment. Your dentist and/or orthodontist should monitor them in order to determine when and if the third molars need to be removed.

*Continued on next page*

Patient or Parent/Guardian Initials_____

**Allergies**
Occasionally, patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.

**General Health Problems**
General health problems such as bone, blood or endocrine disorders, and many prescription and non-prescription drugs (including bisphosphonates) can affect your orthodontic treatment. It is imperative that you inform your orthodontist of any changes in your general health status.

**Use of Tobacco Products**
Smoking or chewing tobacco has been shown to increase the risk of gum disease and interferes with healing after oral surgery. Tobacco users are also more prone to oral cancer, gum recession, and delayed tooth movement during orthodontic treatment. If you use tobacco, you must carefully consider the possibility of a compromised orthodontic result.

**Temporary Anchorage Devices**
Your treatment may include the use of a temporary anchorage device(s) (i.e. metal screw or plate attached to the bone). There are specific risks associated with them.

It is possible that the screw(s) could become loose which would require its/their removal and possibly relocation or replacement with a larger screw. The screw and related material may be accidentally swallowed. If the device cannot be stabilized for an adequate length of time, an alternate treatment plan may be necessary.

It is possible that the tissue around the device could become inflamed or infected, or the soft tissue could grow over the device, which could also require its removal, surgical excision of the tissue and/or the use of antibiotics or antimicrobial rinses.
It is possible that the screws could break (i.e. upon insertion or removal). If this occurs, the broken piece may be left in your mouth or may be surgically removed. This may require referral to another dental specialist.

When inserting the device(s), it is possible to damage the root of a tooth, a nerve, or to perforate the maxillary sinus. Usually these problems are not significant; however, additional dental or medical treatment may be necessary.

Local anesthetic may be used when these devices are inserted or removed, which also has risks. Please advise the doctor placing the device if you have had any difficulties with dental anesthetics in the past.

If any of the complications mentioned above do occur, a referral may be necessary to your family dentist or another dental or medical specialist for further treatment. Fees for these services are not included in the cost for orthodontic treatment.

Patient or Parent/Guardian Initials_____

**ACKNOWLEDGEMENT**

I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented in this form. I also understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with the undersigned orthodontist(s) and have been given the opportunity to ask any questions. I have been asked to make a choice about my treatment. I hereby consent to the treatment proposed and authorize the orthodontist(s) indicated below to provide the treatment. I also authorize the orthodontist(s) to provide my health care information to my other health care providers. I understand that my treatment fee covers only treatment provided by the orthodontist(s), and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment.

_____
Signature of Patient/Parent/Guardian Date

_____
Signature of Orthodontist/Group Name Date

_____
Witness Date

**CONSENT TO UNDERGO ORTHODONTIC TREATMENT**
I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment, and to the above doctor(s) and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor(s) for the above individual. I fully understand all of the risks associated with the treatment.

**AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION**
I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has(have) no responsibility for any further release by the individual receiving this information.

**CONSENT TO USE OF RECORDS**

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, research, education, or publication in professional journals.

_____
Signature Date

_____
Witness Date

I have the legal authority to sign this on behalf of

_____
Name of Patient

_____
Relationship to Patient

Notes

ORTHODONTIC
Specialists of Florida

# 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 our Privacy Officer by phone or mail as follows: info@fl4braces.com or (855)272-2374. To file a complaint with the Secretary of HHS, send your complaint to:
Office for Civil Rights, Attn: Regional Manager, U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, S.W., Atlanta, GA 30303-8909 or (800)368-1019

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

ORTHODONTIC Specialists of Florida

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

*SECTION A: GIVING PATIENT CONSENT*

Patient Name _____ Patient Social Security# ____-___-_____ Patient Account # _____

Patient Address _____

E-mail _____ Telephone (_____)_____-_____

*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 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 protected health information, and of other important matters about your 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 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 Officer: PRIVACY OFFICER
Telephone: (855) 272-2374
Email:. info@fl4braces.com
Website: www.Florida4Braces.com
Corporate Address: 13535 Feather Sound Drive Ste. 220 Clearwater, FL 33762

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 Privacy Officer listed above. Please understand that revocation of the 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 if you revoke this Consent.
SIGNATURE

PRINTED NAME OF PATIENT/PARENT GUARDIAN

I, _____ have received a copy of the Notice of Privacy Practices for the above named company and had the 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 acknowledging receipt of the Notice of Privacy Practices and giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature_____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____ Relationship to Patient _____

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my 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 that I have revoked my consent.

Signature_____ Date _____