Brett M. Buckman, DDS MS
Orthodontic Specialists for Children and Adults
8500 Bluffstone Cove, Suite A -104
Austin, TX 78759
(512) 345-0311

BUCKMAN ORTHODONTICS

American Association of Orthodontists

Please edit any incorrect information and fill out all of the blanks below.

Patient Name: _____
Nickname: _____ DOB: _____
Gender: _____
Address: _____
City, State, Zip Code: _____

Home Phone: _____ Parent E-mail: _____

Cell Phone: _____
How would you like us to contact you during the day? (Circle one)
Home Work Cell Email

CHIEF COMPLAINT(s): _____

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

Dentist Name: _____ Last Seen: _____
Is the patient currently under the care of a physician? □ Yes □ No

If so, for what reason(s)? _____

_____ Doctor Name: _____

Patients Hobbies/Interests: _____

If Patient is a Minor:

Name of Father: _____ SSN: _____

Address: _____ DOB: _____

City, State, Zip Code: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Cell Phone: _____

Insurance Phone: _____

Name of Mother: _____ SSN: _____

Address: _____ DOB: _____

City, State, Zip Code: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Cell Phone: _____

Insurance Phone: _____

Siblings not in treatment: **Date of Birth**

1. _____
2. _____
3. _____

Signature _____ Date _____ Relation to Patient _____

Welcome to Buckman Orthodontics! Please complete the following health questionnaire as completely as possible and feel free to write additional information if necessary.

Please check the main concerns below:

Crowding (crooked teeth)___
Spacing ___
Mouth too small ___
Irregular shaped teeth ___
Missing Teeth ___
Impacted teeth ___
Flared or Buck teeth ___
Overbite ___
Underbite ___
Crossbite ___
Openbite ___
Gummy Smile ___
Irregular facial proportions___
Grind/clench teeth ___
Clicking in jaw ___
Ringing in ears ___
Headaches ___
Facial pain ___
Neck pain ___
Jaw pain ___
Other _____

Other family members with same problems?_____
_____
_____
_____

Patient's current physical health?
____Good ___Fair ___Poor

Patient's current emotional health?
___Good ___Fair ___Poor

Please list all medications taken by patient:

Medication	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How often does the patient have dental checkups?

___ Once a year
___ Twice a year
___ More than twice a year
___ Only in an emergency
___ Never

Does the patient have a history of the following conditions?

NONE____

AIDS/HIV ___
Hepatitis ___
Heart Disease/Murmur ___
Kidney Disease ___
Tuberculosis ___
Mononucleosis ___
Asthma ___
Diabetes ___
Prolonged Bleeding ___
Anemia ___
Endocrine Problems ___
Epilepsy ___
Tonsillitis ___
Tonsils Removed ___
Adenoids Removed ___
Autoimmune disorder ___
High Blood Pressure ___
Low Blood Pressure ___
Blood Disease ___
Bone Disorder___
Cancer ___
Dizziness ___
Sleep Disturbance ___
Snoring ___
Eating Disorder ___
Mouth-breathing ___
Cleft lip/palate ___
Head or Facial injury ___
Emotional stress ___
Nail biting ___
Finger or thumb sucking ___
Previous TMJ treatment ___
Previous ortho treatment ___
Plays musical instrument-Type:
_____

Other: _____

_____

Allergy to drugs: _____
Allergy to Latex: ___
Allergy to Nickel ___
Allergies-Seasonal ___
Antibiotic Premedication ___

Has the patient reached puberty?
___ No
___ Yes-Approx. date _____

Does the patient have difficulty chewing?
___ No ___ Yes-Describe_____
_____
_____

Has the patient been told they have a tongue thrust swallowing pattern?
___ No
___Yes

Has the patient had a previous orthodontic exam/consultation?
___ No
___ Yes-When _____

What is the patient's interest in orthodontic treatment?
___ Wants treatment
___ Willing if necessary
___ Unwilling but agrees
___ Unwilling

Any additional information not already covered? _____
_____
_____
_____
_____
_____

Patient Name _____

Signature of person completing form _____ Date _____

Relationship _____

NOTICE OF HEALTH INFORMATION 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 see the receptionist to request a copy.

Understanding Your Health Record/Information

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. Requests for restrictions on disclosures to your health plan for health care items or services paid out of pocket must be accepted.
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524 and HB 300 (paper or electronic).
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- receive a notice of a breach of "unsecured" protected health information

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- notify you of a breach of "unsecured" protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information (PHI) we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose or sell your health information without your written authorization, except as described in this notice.

To Report a Problem

If you have questions and would like additional information, you may contact the Privacy Officer at this office.

If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

Treatment: Information obtained by a nurse, physician or other member 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 physician 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. In that way, the physician will know how you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Health Operations:

1. **Risk Management** - Members of the medical staff or the risk or quality improvement staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

2. **Business Associates** - There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services, transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

3. **Notification –** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

4. **Communication With Family** - Health professionals, using their best judgment, 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.

5. **Research** - We may disclose 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.

6. **Funeral Directors** – We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

7. **Organ Procurement Organizations** – Consistent with applicable law, we may disclose 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.

8. **Marketing** – We may contact you to provide appointment reminders or face- to- face information about treatment alternatives or other health-related benefits and services that may be of interest to you.

9. **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, recalls, repairs or replacement.

10. **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.

11. **Public Health –** 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.

12. **Law Enforcement –** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

13. **Schools** - We may disclose childhood immunization records to schools.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

This notice is effective as of __11/14____ and will remain in effect until revised.

NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM

BUCKMAN
ORTHODONTICS

The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the receptionist. Review the policy carefully and let us know if you have any questions or requests.

By my signature below, I acknowledge that I have received the Notice of Health Information Practices of Buckman Orthodontics. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____

Name of Patient

_____

Signature of Patient or Guardian if patient is a minor

_____

Date

BUCKMAN
ORTHODONTICS

PHOTO CONSENT

I consent to the use of my or my child's photographs and x-rays for the purposes of marketing the practice of Buckman Orthodontics in the following mediums: Buckman Orthodontics website, social media (Facebook, Twitter, etc.), printed office brochures, newsletter, in-office displays, professional presentations, or journals.

_____

SIGNATURE OF PATIENT/PARENT OR GUARDIAN

_____ _____

DATE WITNESS