DIAMOND INVISALIGN PROVIDER 2018
DR. PAUL YURFEST
DR. KRISTIN L. HUBER

WEST PACES FERRY ORTHODONTICS
ATLANTA'S TOP PROVIDER OF INVISALIGN TREATMENT

75 YEARS PIONEERING EXCELLENCE
WPORTHO.COM
(404) 262-2212

NEW PATIENT INFORMATION

PATIENT INFORMATION

Last_____First_____Mi_____ Sex M F
Age_____ Birthdate_____ Social Security #_____
Address_____
City_____ State_____ Zip_____ Email _____

Home Phone _____Work Phone _____Cell Phone _____
Employer Name _____ Parent/Guardian Name_____

Ocupation_____

RESPONSIBLE PARTY INFORMATION

Name Last _____First_____ Marital Status_____
Address_____ City_____ State _____ Zip_____
Home Phone _____Work Phone _____Email _____

Social Security #_____ Birthdate_____

Relation To Patient_____ Occupation_____

EMERGENCY INFORMATION

Name of the nearest relative not living with you _____

Complete Address_____
Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insurance ID# _____
Insured's Birth-date _____ Insured's Employer Name _____
Employer Address_____
Insurance Co. Name_____ Group #_____ Plan Type_____
Insurance Co. Address_____ Insurance Phone #_____

Name Of Family Dentist_____
Dental Address_____
Phone_____

Who Referred You To Our Office? _____

I certify that the above information is accurate, and I agree to inform this office of any information changes.

_____
Patient/Guardian Signature Date

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Medical History

It is extremely imperative for your benefit, and others, that you fill this form out completely. Thank You.

Please indicate (by checking) if you have had any of the following:

- ☐ Heart Disease
- ☐ Asthma
- ☐ A Chronic Cough
- ☐ High Blood Pressure
- ☐ Kidney Disorder
- ☐ Stomach Disorder
- ☐ Diabetes
- ☐ Sickle Cell Disease
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Nervous Disorder
- ☐ Thyroid Disorder
- ☐ Oral Surgery/Trauma
- ☐ Bleeding Disorder
- ☐ Psychiatric Treatment
- ☐ Special Diets
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Scarlet Fever
- ☐ Immune Deficiency
- ☐ Shortness of Breath
- ☐ Fever Blister
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cleft Palate
- ☐ Liver Disease
- ☐ Anemia
- ☐ Bone Density

Patient Name:

Who is your Physician?

Women, are you pregnant? Yes / No

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Other Antibiotics

Any other allergies to medications or substances:

List any current medications you are taking:

List any disease, condition, or current problem not listed above:

Orthodontic History

Do you like your smile? Yes / No

Have you consulted another orthodontist? Yes / No

Have any other family members had orthodontic treatment? Yes / No

Have you had previous Orthodontic treatment? Yes / No

What are your concerns/reasons for desiring Orthodontic Treatment?

Patient/Guardian Signature: Date:

Dr. Signature: Date:

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PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

_____

Please Print (Last Name) (First Name) (M.I.)

DO WE HAVE YOUR PERMISSION TO...?

Send a recall appointment reminder to your home? Y_____ N_____

Leave appointment, billing or dental information on
your answering machine/voice mail/ e-mail: Y_____ N_____

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

_____ _____
Signature of Patient/Parent or Legal Guardian Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices.

_____ _____
Signature of Patient/Parent or Legal Guardian Date

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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.

The Health Insurance Portability & Accountability Act of 1996 (HIPPAA) requires all health care records and other individually identifiable health information (protected health information) used of disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPAA provides penalties for covered entities that misuse personal health information. As required by HIPPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state, or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of

a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations. The rights to access, inspect and copy your PROTECTED HEALTH INFORMATION. The right to request an amendment to your PROTECTED HEALTH INFORMATION. The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

FOR MORE INFORMATION ABOUT OUR PRIVACY PRACTICES, PLEASE CONTACT:

Our office at:
1218 West Paces Ferry Road NW
Suite 100
Atlanta, GA 30327
(404)262-2212

For more information about HIPPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll free)