Welcome to Our Office!

MAHAFFEY ORTHODONTICS

PATIENT INFORMATION

PLEASE COMPLETE ALL OF THE INFORMATION REQUESTED

DATE_____ NICKNAME_____

PATIENT NAME_____ AGE_____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY STATE ZIP

HOME PHONE_____ BIRTHDATE_____ MALE_____ FEMALE_____

EMAIL ADDRESS_____

FAMILY DENTIST_____ ADDRESS_____

DENTIST PHONE_____ LAST VISIT_____ SCHOOL_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

IS THERE ANOTHER FAMILY MEMBER WE HAVE TREATED?_____

RESPONSIBLE PARTY INFORMATION

NAME_____ MARITAL STATUS_____
LAST FIRST MIDDLE

RESIDENCE_____
STREET CITY STATE ZIP

MAILING ADDRESS_____
STREET CITY STATE ZIP

HOW LONG AT THIS ADDRESS?___ HOME PHONE_____ WORK PHONE_____

EMAIL ADDRESS_____

PREVIOUS ADDRESS (*IF LESS THAN THREE YEARS*) _____

SOCIAL SECURITY NUMBER_____ BIRTHDATE_____ RELATIONSHIP TO PATIENT_____

EMPLOYER _____ OCCUPATION_____ NO. YEARS EMPLOYED_____

PARENT OR SPOUSE'S NAME_____ RELATIONSHIP TO PATIENT_____
LAST FIRST MIDDLE

EMPLOYER _____ OCCUPATION_____ NO. YEARS EMPLOYED_____

SOCIAL SECURITY NUMBER_____ BIRTHDATE_____ WORK PHONE_____

INSURANCE INFORMATION

DO YOU HAVE ORTHODONTIC INSURANCE? YES NO IS THERE MORE THAN ONE COVERAGE? YES NO

1. INSURED'S NAME _____ INSURED'S SOCIAL SECURITY NUMBER_____

   INSURANCE COMPANY_____ GROUP # _____ EMPLOYEE ID_____

   INSURANCE CO. ADDRESS_____ INSURANCE CO. PHONE#_____

2. INSURED'S NAME _____ INSURED'S SOCIAL SECURITY NUMBER_____

   INSURANCE COMPANY_____ GROUP # _____ EMPLOYEE ID_____

   INSURANCE CO. ADDRESS_____ INSURANCE CO. PHONE#_____

Please Complete the Medical and Dental Health History on the BACK of this Form

MEDICAL HISTORY

1. IS THE PATIENT IN GOOD HEALTH? .....YES NO

2. ANY HISTORY OF MAJOR ILLNESS OR HEALTH PROBLEMS?.....YES NO

3. HAS THE PATIENT BEEN TREATED FOR ANY OF THE FOLLOWING:

HEPATITIS	YES	NO	ASTHMA	YES	NO
AIDS	YES	NO	KIDNEY PROBLEMS	YES	NO
DIABETES	YES	NO	PROLONGED BLEEDING	YES	NO
RHEUMATIC FEVER	YES	NO	TUBERCULOSIS	YES	NO

4. DOES PATIENT NEED ANTIBIOTIC PREMEDICATION FOR ANY DENTAL PROCEDURES? .....YES NO
5. HAVE THE TONSILS AND ADENOIDS BEEN REMOVED? .....YES NO

BOTH O TONSILS ONLY O ADENOIDS ONLY O AT WHAT AGE? _____)

6. HAS THE PATIENT EVER HAD AN EAR/NOSE AND THROAT SPECIALIST EXAMINATION?.....YES NO
7. LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN_____
Give Reasons_____

8. LIST ANY ALLERGIES OR DRUG SENSITIVITIES _____

9. NAME OF PERSONAL PHYSICIAN _____

QUESTIONS #10 AND #11 ARE FOR CHILDREN AND ADOLESCENT PATIENTS ONLY

10. FOR GROWTH ASSESSMENT REASONS, HAS THE PATIENT REACHED PUBERTY?.....YES NO
11. YOUR ESTIMATE OF THE RATE OF GROWTH IN THE LAST 6 MONTHS: SLOW MEDIUM FAST

Height: Patient:_____ Mother:_____ Father:_____

In your own words, why are you seeking orthodontic care (what do you think is the problem?) _____

_____

_____

DENTAL HISTORY

HAS THE PATIENT SEEN AN ORTHODONTIST PREVIOUSLY? (Treatment or 2nd Opinion).....YES NO

WAS ANY ORTHODONTIC TREATMENT RENDERED? .....YES NO

ANY BABY OR PERMANENT TEETH REMOVED BY DENTIST? .....YES NO

HAS THE PATIENT BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? .....YES NO

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH, OR TEETH? .....YES NO

ANY DIFFICULTY IN BREATHING THROUGH THE NOSE—AWAKE OR ASLEEP? (Mouth breathing?).....YES NO

ANY SPEECH PROBLEMS? .....YES NO

ANY HABITS SUCH AS THUMBSUCKING, LIP BITING, NAILBITING? (specify)_____ .....YES NO
(Age stopped_____)

DOES THE PATIENT HAVE ANY CLICKING OR DISCOMFORT IN THE JAW JOINTS (near the ears).....YES NO

DOES THE PATIENT CLENCH OR GRIND THE TEETH? .....YES NO

NAME AND PHONE# TO CALL IN CASE OF EMERGENCY: _____Phone_____

***I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED*

_____

SIGNATURE OF CUSTODIAL PARENT OR GUARDIAN **DATE**

MAHAFFEY ORTHODONTICS

Michael J. Mahaffey, D.M.D., M.S.
268 South Peachtree Parkway
Peachtree City, Georgia 30269
Phone: 770-487-6439

Authorization for Release of Information – Compound Release

Patient Name: _____ Date of Birth _____

Mahaffey Orthodontics is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/means of communication approved to receive information.	**Check type of information that can be given to person/entity on the left in the same section.**
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Treatment Plan
☐ Email communication – **Provide email address*** _____ *For email communication, please accept the disclosure below:	☐ Financial ☐ Treatment Plan ☐ Appointment reminders
☐ Text communication – **Provide number** * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminders ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is *not* sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Permission to release video and photographs ☐ Decline release of video and photographs	☐ May be posted on Social Media ☐ May be posted in office

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: _____ Date: _____

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on _____.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

MAHAFFEY
ORTHODONTICS

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect.

Effective Date: April 14, 2003 **Revised: May 1, 2017**

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy and the new terms of our effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

For Example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we charge you a reasonable, cost-based free for responding to these additional request.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (**You must make your request in writing.**) Your request must specify6 the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you think we have violated your rights or you have a complaint about our privacy practices you can contact our Privacy Officer. You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us. If you file a complaint we will not retaliate against you for filing a complaint.

Privacy Officer: Dana Lindval
Telephone: 770-487-6439
Fax: 770-487-7539
Email: dana@peachtreecitybraces.com
Address: 268 South Peachtree Parkway, Peachtree City, GA 30269

Michael J. Mahaffey, D.M.D., M.S.
268 South Peachtree Parkway
Peachtree City, GA 30269
770-487-6439

MAHAFFEY
ORTHODONTICS

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name and Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:
_____
- ☐ Other: _____
_____

Prepared By: _____

Michael J. Mahaffey, D.M.D., M.S.
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Peachtree City, GA 30269
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