



Welcome to Our Practice!

We would like to welcome you to our office. Our goal is to make your visit pleasant and informative. We are excited that you have made this commitment to improving your dental health. You will be pleased with the benefits that orthodontics can make to your overall health. Thank you for taking the time to fill out this form. Please remember to bring it to your exam appointment.

Please tell us about yourself: (Please print)

Today's Date: _____

Name: _____ Male _____ Female _____ Pronouns: _____

Nickname: _____ Birthdate: _____ / _____ / _____ Age: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____ SS #: _____

Home Address: _____

City _____ State _____ Zip _____

How would you like to receive correspondence?: _____ Email _____ Standard Mail

All appointments will be confirmed via text – Cell # _____

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced _____ Separated

Employer: _____ Job Title: _____

Work Phone #: _____ ext: _____ How long at current job: _____

Hobbies/Sports: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Medical History:

Have you ever been evaluated for or have you had orthodontic treatment before? _____ Yes _____ No

Have there been any injuries to the face, mouth, teeth, or chin? _____ Yes _____ No

Have you been informed of any missing or extra permanent teeth? _____ Yes _____ No

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? _____ Yes _____ No

Do you floss your teeth daily? _____ Yes _____ No

Have you pregnant or trying to become pregnant? _____ Yes _____ No

Physician: _____ Phone #: _____ Date of last visit: _____

Are you currently under the care of a physician? _____ Yes _____ No

Please describe your physical health: _____ Good _____ Fair _____ Poor

Please list all the medications that you are currently taking: _____

Have you ever had any of the following medical conditions?

| | Yes No | | | Yes No | | | Yes No | |
|------------------------------|--------|--|-------------------------|--------|--|-------------------------|--------|--|
| Abnormal Bleeding | | | Diabetes | | | Asthma | | |
| Handicaps/Disabilities | | | Hemophilia | | | Hearing impairment | | |
| Allergies to any medications | | | Heart Murmur | | | Any hospital stays | | |
| Allergy to latex | | | Any operations | | | Hepatitis | | |
| Allergy to metal | | | HIV + AIDS | | | Cancer | | |
| Other allergies | | | Congenital heart defect | | | Rheumatic/Scarlet Fever | | |
| Convulsions/Epilepsy | | | Tuberculosis (TB) | | | Kidney/liver problems | | |

Please comment on any yes answers: _____

Please list any habits (thumb/finger sucking, nail biting, etc.) that you have or had in the past: _____

Dentist: _____ Did they refer you to us? ____ Yes ____ No

Is there someone else that we can thank for referring you to our office?: _____

Please list any family members that are or have been in treatment in our office: _____

Person responsible for account:

Name: _____ Relationship: _____

Home #: _____ Cell #: _____

Employer: _____ Work #: _____ Ext: _____

Best time to call?: _____ Is it okay to call at work? ____ Yes ____ No

Primary Orthodontic Insurance:

Insurance Company Name: _____ Phone #: _____

Insurance Company Address: _____

Group Number: _____ Policy owner's name: _____

Relationship to patient: _____ Birthdate: _____

SS # or ID #: _____ Policy owner's employer: _____

Secondary Orthodontic Insurance:

Insurance Company Name: _____ Phone #: _____

Insurance Company Address: _____

Group Number: _____ Policy owner's name: _____

Relationship to patient: _____ Birthdate: _____

SS # or ID #: _____ Policy owner's employer: _____

What are the main concerns that you would like orthodontics to address?: _____

I understand that the information that I have given is correct to the best of my knowledge. That it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status and I consent to treatment evaluation (including x-rays, photos, and treatment planning).

Signature

Date

I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental benefits of my plan directly to this dental office. I also authorize the release of any information necessary to process dental insurance. I understand that I am responsible for any portion that my insurance carrier does not pay.

Signature

Date

Acknowledgement of Receipt of Notice of Privacy Practices

Dr. Jeffrey E. Kashner Orthodontics
27015 169th Place SE Suite 201
Covington, WA 98042

*** You May Refuse to Sign This Acknowledgment***

I have received a copy of this office's Notice of Privacy Practices.

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Sleep Apnea Questionnaire

Name: _____

Date: _____

Your age: _____ Your sex: ___ Male ___ Female

Please complete the following:

Obstructive sleep apnea symptoms

| | | |
|---|-----|----|
| Do you fall asleep during the day? | Yes | No |
| Have you fallen asleep while driving? | Yes | No |
| Do you have disrupted sleep? | Yes | No |
| Do you urinate frequently during the night? | Yes | No |
| Do you snore heavily at night? | Yes | No |
| Do you talk in your sleep? | Yes | No |
| Do you suffer from daytime fatigue? | Yes | No |
| Do you experience daytime sleepiness? | Yes | No |
| Have you had recent weight gain? | Yes | No |
| Do you have high blood pressure? | Yes | No |
| Do you take blood pressure medication? | Yes | No |
| Do you have an irregular heartbeat? | Yes | No |
| Do you suffer from depression? | Yes | No |
| Do you have headaches when you wake up? | Yes | No |
| Does your spouse see you stop breathing during sleep? | Yes | No |
| Do you drink alcoholic beverages? | Yes | No |
| Do you take sedative-type medication? | Yes | No |

Airway

| | | |
|---|-----|----|
| Do you have difficulty breathing through your nose? | Yes | No |
| Are you a mouth breather? | Yes | No |
| Do you have difficulty closing your lips? | Yes | No |
| Do you have dry mouth problems? | Yes | No |
| Do you have speech clarity problems? | Yes | No |

Please continue on backside >



How do you control your sleep apnea?

Restrict alcoholic beverages

Restrict sedative medication

Sleep upright

Sleep on side

Sleep on back

Sleep with special pillow positions

Other:

Have you had treatment for sleep apnea?

Weight loss

CPAP (continuous positive airway pressure)

Dental appliance

Soft palate surgery

Nasal Surgery

Other:

Epworth Sleepiness Scale

Patients Name _____ Date _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to imagine how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = Would *never* doze

1 = *Slight* change of dozing

2 = *Moderate* chance of dozing

3 = *High* chance of dozing

| Situation | Chance of Dozing or Sleeping |
|--|------------------------------|
| Sitting and reading | |
| Watching TV | |
| Sitting inactive in a public place | |
| Being a passenger in a motor vehicle for an hour or more | |
| Lying down in the afternoon | |
| Sitting and talking to someone | |
| Sitting quietly after lunch (no alcohol) | |
| Stopped for a few minutes in traffic while driving | |
| Total Score (add the scores up) (This is your Epworth score) | |



27015 169th Place SE Suite 201
Covington, WA 98042

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **5/20/2014**, and will remain in effect until we replace it.

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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as 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, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you 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 us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI 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 information.

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

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

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We 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, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health 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 us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We 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 us using the information listed at the end of this Notice for an explanation of our 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 health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we 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 our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are 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 our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information 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 our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: *Dr. Jeffrey E. Kashner DDS, MSD, PLLC*

Telephone: *(253) 630-3331* Fax: *(253) 630-6881*

Address: *27015 169th Place SE Suite 201 Covington, WA 98042*

E-mail: *info@nicesmilesonline.com*

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