



Centerville Location
9114 Dayton Lebanon Pike
Centerville, OH US 45458
Phone: 937-301-0024

Springboro Location
888 W. Central Ave.
Springboro, OH US 45066
Phone: 937-746-3405

Confidential Patient Information

Legal First Name: _____

Legal Last Name: _____

Address: _____

City: _____ **State:** ____ **Zip:** _____

Birthdate: _____ Male Female

Dentist: _____

Dentist's Address: _____

Emergency Contact:

Name of nearest relative NOT living with you:

Emergency Contact Phone: _____

Relationship to Patient: _____

How did you hear about our office?

Dentist: _____ Patient: _____ Parent of Patient: _____

Yelp Facebook Google Ad: _____ Other: _____

The American Association of Orthodontists recommends all children have a check-up with an orthodontist by age 7.

We will send you a reminder when a sibling is reaching age 7 to come in for a complimentary exam.

Sibling Name _____ **Birthdate:** _____ Male Female

Sibling Name _____ **Birthdate:** _____ Male Female

Responsible/Financial Party

(complete blue items below if you are an adult patient)

Relationship to Patient:

mother father other _____

First Name: _____

Last Name: _____

Address: _____

City: _____ **State:** ____ **Zip:** _____

Primary Phone: _____ home cell

Would you like to receive CALL reminders to this #? yes / no

Would you like to receive TEXT reminders to this #? yes / no

Is it ok to leave treatment & financial messages at this #? yes / no

Social Security #: _____

Email: _____

Would you like to receive EMAIL reminders? yes / no

Is it ok to send treatment & financial messages to this email? yes / no

single married divorced

Other Responsible Party

(another person you authorize to access patient info)

Relationship to Patient:

mother father other _____

First Name: _____

Last Name: _____

Address: _____

City: _____ **State:** ____ **Zip:** _____

Primary Phone: _____ home cell

Would you like to receive CALL reminders to this #? yes / no

Would you like to receive TEXT reminders to this #? yes / no

Is it ok to leave treatment & financial messages at this #? yes / no

Social Security #: _____

Email: _____

Would you like to receive EMAIL reminders? yes / no

Is it ok to send treatment & financial messages to this email? yes / no

single married divorced

Patient Health Information

Medical Doctor's Name: _____

Medical Doctor's Phone: _____

YES NO

- Pregnant
- Latex allergy (reaction to balloons, rubberbands, etc.)
- Other allergy _____
- Current medications _____
- Heart condition _____
- Frequent headaches
- Hepatitis
- HIV/AIDS

YES NO

- Injuries to face, jaw, mouth or teeth
- Any speech problems/therapy
- Grind or clench teeth
- Pain, tenderness or noise in jaw
- Discomfort from teeth or gums
- Are there any other dental/medical problems of which our doctors should be aware

Dental Insurance Information

Do you have insurance that covers orthodontic treatment? YES (complete below) NOT SURE (complete below) NO

Insurance Company Name: _____ Insurance Company Phone: _____

Insurance Company's Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Employer's Name: _____

Subscriber's Social Security #: _____ Subscriber's Birthdate: _____

Our office will send a claim to your insurance company on your behalf. The signer of the financial agreement with Sprowls Orthodontics is responsible for the financial contract in its entirety. Any non-payment or claim denial from the insurance company is not the responsibility of Sprowls Orthodontics.

Signature: _____

Date: _____

_____ **(Initial)** Cancellation policy: I understand I must give at least 1 (one) business day's notice to change or cancel my appointment in order to avoid being charged a \$25 fee.

_____ **(Initial)** The information provided is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of changes to any information or the patient's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services that the patient may need. I understand that I am responsible for the payment of services rendered.

_____ **(Initial)** I authorize the release of dental/medical/insurance records to other dental/medical offices involved in the patient's continued orthodontic/dental treatment.

_____ **(Initial)** I acknowledge that I have received your NOTICE OF PRIVACY PRACTICES containing a complete description of the uses and disclosures of my health information. I understand that the organization has the right to change its NOTICE OF PRIVACY PRACTICES, and that I may contact this organization at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____



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Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice: 1/1/2020