MARKIN* & PARK* ORTHODONTICS
Specialist in Orthodontics for Children and Adults
*Certified: American Board of Orthodontics

Patient Information:

Date _____
Patient's Full Name _____ Nickname _____
____ Male _____ Female Age _____ Date of Birth _____ Best Phone # _____
Contact Email _____
Home Address _____ Zip Code _____
How do you prefer to receive appointment reminders? (Circle all that apply): Text Email Phone
How may we contact you in regards to your treatment? (Circle all that apply): Text Email Phone
How did you hear about our office? Website/Internet Friend/Family (Name: _____) Dentist / Healthcare Professional
Patient's General Dentist _____ Date of last visit _____
Patient's Physician _____
Has anyone in the family had orthodontic treatment? Yes (Relation: _____) No
Has another orthodontist been consulted previously? Yes No

If patient is an adult, please fill out this section:
Employed by _____ Bus Address _____ Phone _____
Spouse's Full Name _____ Employed by _____ Phone _____

If patient is a child, please fill out this section:
School _____ Grade _____
Father's Name _____ Mother's Name _____
Parents' Marital Status: Single Married Divorced Patient lives with: _____
Father Employed By _____ Bus. Address _____ Phone _____
Mother Employed By _____ Bus. Address _____ Phone _____

Is there any dental insurance we can check for you? Yes No
If yes, list Insurance Company _____ Phone # _____ Address State _____
Policy Holder _____ DOB _____ SSN / ID# _____ Employer _____

List any relatives treated at this office (Name and relation to patient) _____

Patient Health Information and Medical / Dental History:

List any **medications** currently being taken _____
List any **allergies** (including nickel or latex) _____

Please circle any of the following which you have experienced, been diagnosed, or have been treated for:

Abnormal / Prolonged Bleeding	Bone Disorder	Gastrointestinal Disorder	Nervous Disorder
ADD / ADHD	Cancer / Tumor	Heart Trouble (inc. murmur)	Pneumonia
Anemia	Congenital Heart Defect	Hepatitis / Jaundice	Rheumatic Fever
Arthritis	Diabetes	High Blood Pressure	Severe / Frequent Headaches
Asthma or Hay Fever	Dizziness or Fainting	HIV + / AIDS	Severe Head / Face Injury
Autism	Epilepsy	Kidney Trouble	Tuberculosis

Other: _____

Have your tonsils or adenoids been removed? Yes No At what age? _____
Female patients … are you pregnant or trying to get pregnant? Yes No
Are there any lost or chipped any teeth? Yes No
Have there been any injuries to face, mouth, or teeth? Yes No
Is any part of your mouth sensitive to temperature or pressure? Yes No
Are you a mouth breather? Yes No
Do you play a musical wind instrument? Yes (which? _____) No
Are your teeth or jaws ever uncomfortable when waking in the morning? Yes No
Are you aware of your jaw clicking or popping? Yes (left side, right side, both?) No
Are you aware of clenching your teeth during the day, or grinding teeth at night? Yes (clench, grinding, both) No
Do you have tension headaches? Yes No
Have you ever experienced chronic ringing in your ears? Yes No

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 PRVACY OF YOUR HEALTH INORMATION 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 this Notice while it is in effect. This Notice takes effect April 14, 2003, 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 that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice 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 health care 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 to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence of 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 disclosure 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, or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we way 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 filled prescriptions, 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 institution or law enforcement officials having lawful custody of 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, emails, text 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. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.45 per page and $25 per hour for staff time to locate and copy your health information, as well as postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have a 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 six years, but not before April 14, 2003.

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 these additional requests.

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 specify 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 website or by electronic mail (email), you are entitled to receive this notice in written form.

QUESTIONS AND CONCERNS

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 you disagree with a decision we made about access to your health information or in a 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 may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

Markin & Park Orthodontics
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Email: orthocares7@gmail.com
Address: 9650 Santiago Road Suite 111 Columbia, MD 21045

PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone / fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.)
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.)
- To certifying, licensing, and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure, or accreditation
- Internally, to all staff members who have any role in your treatment
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment; and / or
- We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to evoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information
- Request confidential communication of your protected health information
- Inspect and obtain copies of your protected health information through asking us
- Amend or modify your protected health information in certain circumstances
- Receive an accounting of certain disclosures made by us of your protected health information; and
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation.

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information
- To abide by the terms of our Privacy Notice that is currently in effect
- To advise you of our right to change the terms of this Privacy Notice and to make the new Notice provisions effective for all protected health information maintained by us and that, if we do so, we will provide you with a copy of the revised Privacy Notice

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information
- Amend your protected health information if, for example, it is accurate and complete
- Provide an atmosphere that is totally free of the possibility that your protected health information by be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have reviewed a copy of this Privacy Notice.

_____ _____

Patient / Parent if minor Date