THE BRACE PLACE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

The Brace Place
5641 Naples Blvd
Naples, FL 34109

Dr. Albert and Dr. Thomas, Orthodontic Specialists

Patient Information Today's Date: _____

Patient's Name: _____ _____
First *Last*

Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Home Phone _____ - _____ Cell Phone _____ - _____ Mom Dad Self Other
Please Circle

E-mail Address: _____ Date of Birth _____

Name of School (if applicable): _____

Responsible Party Name: _____ _____
First *Last*

Employer: _____ Occupation: _____

Spouse's Name: _____ _____
First *Last*

Spouse's Employer: _____ Occupation: _____

Please check the following if treatment and financial information can be shared with another person. If not checked, information will not be shared.
Father: _____ Mother: _____ Stepfather: _____ Stepmother: _____ Guardian: _____
Spouse: _____ Other: _____ _____
First *Last*

Orthodontic Coverage Only: Please make insurance card available for us to copy

Primary Insurance Carrier: _____ Lifetime Max: $ _____

Name of Policyholder: _____ _____
First *Last*

Policyholder Birth Date: _____ Social Security Number:_____

Employer: _____

ID#: _____ Group #: _____

If two Insurance Policies, please list Secondary: _____

Name of Policyholder: _____ _____ Lifetime Max: $ _____
First *Last*

Policyholder Birth Date: _____ Social Security Number:_____

Employer: _____

ID#: _____ Group #: _____

I give my permission to Dr. Albert and/or Dr. Thomas to examine the above named patient.

Signature: _____ Today's Date:_____

Please turn over and fill out Page 2

Patient's Information

Patient's Age: _____

Patient's Dentist: _____

Patient's Physician: _____

How did you hear about us? Family _____ Friend _____ Dentist _____ Other (specify) _____

Who can we thank for referring you to us? _____ _____
First *Last*

Please name family members that are/or have been treated in our office: _____

_____

Reason for Consultation: _____

Would another family member like to be seen? _____ _____
First *Last*

Patient Health History Information:

Are you currently in good health? Yes_____ No_____ Explain: _____
Are you currently taking medication? Yes_____ No_____ Explain: _____
Are you allergic to anything? Yes_____ No_____ Explain: _____
Have you ever had head trauma? Yes_____ No_____ Explain: _____
Do you need to be pre-medicated for any dental work? Yes_____ No_____
If "yes", what prescription do you take to pre-medicate? _____

Check if the patient **has** or **had** any of the following:

____Heart Trouble
____Rheumatic Fever
____Fainting or Dizziness
____Diabetes
____Tuberculosis
____Mononucleosis
____Endocrine Disorder
____Learning Disability
____Thyroid Disorder
____Blood Transfusion
____Epilepsy
____High Blood Pressure
____Anemia
____Bleeding Disorder
____Hepatitis
____ADD/ADHD
____Kidney Disorder
____Malignancies/Tumors
____Radiation Treatment
____Cold Sores
____Herpes
____AIDS/HIV Positive
____Bone Disorder
____Viral Infection

Check if the patient **has** or **had** any of the following:

____Frequent Colds/Flu
____Strep Throat
____Tonsillitis
____Adenitis
____Sinusitis
____Bronchitis
____Asthma
____Mouth Breathing
____Snoring
____Tonsils Removed
____Adenoids Removed
____Otitis (Ear Infection)
____Clenching/Grinding Teeth
____TMJ (Jaw Pain)
____Headaches
____Thumb/Finger Sucking
____Cracked or Chipped Teeth

Any other information you feel we need to know: _____

_____

Thank you for filling out both sides of this form completely