Clark E. Schneekluth, DDS, MS

Specialist in Orthodontics for Children and Adults
6968 Warner Avenue
Huntington Beach, CA 92647
(714) 842-5626

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

I have chosen not to sign this acknowledgement. _____ (please initial)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

_____

_____

_____

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Date_____ Patient #_____ Age:_____D.O.B.___/___/___ Sex M F

Patient's Name:_____

Home Address:_____City_____Zip_____

Home Tel:_____Work:_____Email:_____

Person Responsible For Account

Name:_____ Relation_____

Home Address:_____

Home Phone: _____Work: _____

Family Status / Please complete next 6 lines if patient is under 18 years of age.

Patient's School _____ Patient's Grade _____

Siblings: None _____ Number of Brothers _____ Number of Sisters

Patient Living with: Mother Father Self Other:_____

Father's Name:_____ Employer: _____

Mother's Name _____ Employer: _____

Other Family members with similar orthodontic conditions?
Father Mother Brother Sister Other:_____

Have we treated any other family members?_____ Who? _____

Is patient covered by insurance for orthodontic treatment? Yes No

If Yes, by which company? _____ Tel_____

Subscriber's Name_____ Subscriber's SSN or ID#_____

Subscriber's DOB _____ Subscriber's Group #_____

Subscriber's work address_____Tel_____

Family Dentist:_____ Last Visit: _____
Family Physician_____ Last Visit: _____

Whom may we thank for referring you?
____Dentist____Insurance Patient_____ Other_____

Reasons for seeking Orthodontic treatment?

Please circle **yes** or **no** to all of the following questions. The answers are for the office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation. Do you have or have you had any of the following?

Medical History

Birth defects or hereditary problems	y	n
Bone fractures, any major accidents	y	n
Rheumatoid or arthritic conditions	y	n
Endocrine or thyroid conditions	y	n
Kidney problems	y	n
Diabetes	y	n
Cancer or been treated for a tumor	y	n
Stomach ulcer or hyperacidity	y	n
Polio, mononucleosis, tuberculosis, Or pneumonia	y	n
Problems of the immune system	y	n
Hepatitis, Jaundice or liver problem	y	n
Fainting spells, seizures, epilepsy or Neurologic disease	y	n
Mental health or behavior problems	y	n
Vision, hearing, tasting or speech Difficulties	y	n
Excessive bleeding, anemia or bleeding tendency	y	n
High or low blood pressure	y	n
Easily tired	y	n
Chest pain, shortness of breath or Swollen ankles	y	n
Cardiovascular (Heart) problems	y	n
Skin disorder	y	n
Do you have a normal/good diet	y	n
Frequent headaches/colds/sore throat	y	n
Any history of speech problems	y	n
Eye, ear, nose throat condition	y	n
Hayfever, asthma, sinus trouble, hives	y	n
Tonsils or adenoid conditions	y	n
Tonsils removed	y	n
Allergies or drug reactions	y	n
Have you ever used fen-Phen	y	n

If yes, how long_____

Are you taking medication, nutrient supplements, or Non-prescription medicine y n

If yes, please name them_____

_____

_____

Are you in good physical health y n

Date of last physical exam_____

Dental History

Chipped/injured baby or permanent teeth	y	n
Jaw fractures, cysts, mouth infections	y	n
Root canals treated	y	n
Periodontal (Gum) disease	y	n
Frequent canker sores or cold sores	y	n
Thumb or finger sucking habit	y	n

If yes, until age_____

Abnormal swallowing habit (tongue thrust)	y	n
Mouth breathing habit, snoring, difficulty in Breathing	y	n
Tooth grinding, jaw clenching, jaw clicking Or locking	y	n
Do you have or experience any pain in the muscles Face or around your ears	y	n
Any pain in the jaws or ringing in the ears	y	n
Difficulty encountered in chewing or Jaw opening	y	n
History of supernumerary (extra) or congenitally Missing teeth	y	n
Have any permanent teeth been removed	y	n
Any teeth irritating cheek, lips, tongue or Your palate (roof of mouth)	y	n
Have you ever had orthodontic treatment	y	n
Worn a bite plate or retainer	y	n
Have you recently been under another dentist's Care	y	n

Specialist _____

Allergic to latex (gloves)	y	n
Concerned about spaced crooked or Protruding teeth	y	n
Aware/concerned about over/under developed Jaw	y	n
Any relative with similar tooth or jaw Relationships	y	n
Any wisdom tooth problems	y	n
Have you had a bad dental experience	y	n

How often do you brush_____

How often do you floss _____

Realizing that successful treatment greatly depends upon the patients complete cooperation in the following instructions, keeping appointments, and maintaining good oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? _____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his Staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to my medical or dental status, I will so inform this practice.

Signature of Patient/Guardian_____Date_____

Examining Doctor Signature _____Date_____

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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 YOU 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 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 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 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 to you.

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 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 you 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 you care, of your location, your general condition, or death. If you are present, then prior to use of 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 reasonable 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 official 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, 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 $1.00 for each page, $10.00 per hour for staff time to locate and copy your health information, and 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 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 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 you 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 (e-mail), 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 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 response to a request you made to amend or restrict the use of 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 you 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.

Contact Officer: Paula Olivier
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