ROSE DENTAL GROUP & ORTHODONTICS
2731 S Rose Ave #101, Oxnard, CA 93033
OxnardRoseDental.com
(805) 483-3658

Date:_____

Patient's name _____ Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other_____
Nickname _____ Sex M ☐ F ☐ Birthdate _____ Age _____ Social security #_____

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Spouse's name (if applicable) _____

Home address _____ City, state, zip code _____

Work phone _____ Cell phone _____ Email _____

Preferred method of contact _____

Employer _____ Occupation _____ # years employed _____

General dentist _____ Date last seen_____ Reason _____

Other dentist/specialists currently seeing _____ Reason _____

Reason(s) for seeking an evaluation with our office _____

Whom may we thank for referring you? _____

Names and ages of children in the family _____

Responsible party ☐ Check if same as above OR complete below section

Name _____ Relationship to patient _____

Birthdate _____ Social security #_____

Home address _____ City, state, zip code _____

Work phone _____ Cell phone _____ Email _____

Employer _____ Occupation _____ No. Years Employed _____

Emergency contact name _____ Relationship to patient _____

Work phone _____ Cell phone _____

Primary Orthodontic Insurance

Policy owner's employer _____

Insurance company name _____

Group _____ ID # _____

Address _____

Phone # to verify benefits _____

Policy owner's name _____

Relationship to Patient _____

Birthdate_____Social security # _____

Secondary Orthodontic Insurance

Policy owner's employer _____

Insurance company name _____

Group _____ ID # _____

Address _____

Phone # to verify benefits _____

Policy owner's name _____

Relationship to Patient _____

Birthdate_____Social security # _____

Our office will make every attempt to contact your insurance company(s) based on the information that you provide us. We will verify whether coverage exists for treatment and coverage limits. We file and accept assignment of orthodontic insurance benefits. However, the responsible party is responsible for all amounts unpaid by insurance for any reason. *Typically orthodontic insurance is paid over the course of the treatment and not in one lump sum, regardless of how you pay our office.*

I authorize assignment of insurance benefits to Rose Dental if I have a balance on my account with the office.

Signature of responsible party _____ Date _____

Medical History

Name of medical physician _____ Phone number _____

Is the patient currently under the care of a physician? ☐ Yes ☐ No If yes, please describe _____

Does the patient have a history of major illness? ☐ Yes ☐ No If yes, please describe _____

Check any of the following for which the patient has been treated for or has a history of:

☐ ADD/ADHD	☐ Circulatory problems	☐ Heart murmur	☐ Pacemaker
☐ AIDS or HIV	☐ Cleft lip and/or palate	☐ Heart problems	☐ Psychiatric care
☐ Anemia	☐ Craniofacial syndrome	☐ Hemophilia	☐ Respiratory disease
☐ Arthritis, joint problems	☐ Diabetes	☐ Hepatitis	☐ Shortness of breath
☐ Artificial heart values	☐ Depression	☐ High blood pressure	☐ Sleep apnea
☐ Artificial joints	☐ Eating disorder	☐ Injury to face, head, neck	☐ Skin disorder
☐ Asthma	☐ Endocrine problems	☐ Kidney disease	☐ Speech problems
☐ Back problems	☐ Epilepsy	☐ Liver disease	☐ Stomach ulcer or acid reflux
☐ Blood transfusion	☐ Excessive bleeding/bruising	☐ Learning disability	☐ Stroke
☐ Bone fractures	☐ Fainting or dizziness	☐ Major surgery	☐ Tobacco habit
☐ Cancer or tumor	☐ Frequent earaches	☐ Mitral value prolapse	☐ Tonsil or adenoid condition
☐ Chemical dependency	☐ Frequent headaches	☐ Nervous problems	☐ Tuberculosis
☐ Chemotherapy/ radiation	☐ Glaucoma	☐ Osteoporosis	☐ Venereal disease

Any other significant medical problems/events we should be aware of? _____

Have tonsils & adenoids been removed? ☐ Yes ☐ No If yes, at what age? _____

List any medication that you take:

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

List any allergies or drug sensitivities _____

Dental History

Have you had any injuries to the face, mouth, or teeth? ☐ Yes ☐ No

Have you ever sucked a thumb or fingers? ☐ Yes ☐ No If yes, until what age? _____

Are you a mouth breather? ☐ Yes ☐ No If yes, when? ☐ Daytime ☐ While sleeping ☐ Both

Does anyone in the family have an underbite? ☐ Yes ☐ No

Are you aware of any missing or extra permanent teeth? ☐ Yes ☐ No

How many times a day do you brush your teeth? _____

Have you consulted another orthodontist? ☐ Yes ☐ No

Have you ever received orthodontic treatment? ☐ Yes ☐ No If yes, please explain: _____

Has anyone in the family had braces or received any orthodontic treatment? ☐ Yes ☐ No

In our office? ☐ Yes ☐ No Names: _____

Please classify the patient's desire for treatment: ☐ Excited ☐ Indifferent ☐ Objects

Would you consider surgical treatment if necessary? ☐ Yes ☐ No

What kind of treatment interests you?

☐ Traditional metal braces ☐ Cosmetic braces ☐ Removable aligners ☐ I need more info to make a decision

Please list any other significant dental events that we should be aware of _____

Do you have any special concerns about treatment? _____

To the best of my knowledge, the above information is complete and correct. I will not hold my orthodontist or their staff accountable for any errors or omissions that I have made in completion of this form. I will notify my orthodontist with any changes in my medical or dental history.

Signature _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, Date of Birth _____,
(Patient Name)

request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, Diagnosis (es), test results, date of services.

- Sensitive Protected Health Information
- You may disclose information to my family members and/or non-family members

Please list the name, phone number, and relationship

NAME	PHONE NUMBER	RELATIONSHIP

- You may leave Protected Health Information on my answering machine/voicemail:
  Phone Number _____
- You may leave me a text message: Text Phone Number _____
- You may email me (unencrypted) for dental appointments:
  Email Address _____
- You may fax me for dental information: Fax Number _____
- Other _____

*I would like to receive a copy of this office's Notice of Privacy Practices. ☐ Yes ☐ No

Print Name: _____

Signature: _____ Date: _____
(Patient's Signature (or Guardian, if Minor)

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
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

_____	_____
Staff Initials	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 GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 1/01/2024 and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for our treatment.

Healthcare Operations: We may use and disclose your PHI 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, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. 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 obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI 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 disclosures permitted by your authorization while it was in effect. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. 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. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. 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.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Stephanie Gonzales
Address: Rose Dental - 2731 S Rose Ave #101, Oxnard, CA 93033
Telephone: (805) 483-3658

Email: info@OxnardRoseDental.com