GARFINKLE ORTHODONTICS
HIGH TECH HIGH TOUCH

1616 SW Sunset Blvd., Suite G Portland, OR 97239
503.246.9802
www.GarfinkleOrtho.com

Patient Registration

Patient's Name: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Home Address Street: _____

City: _____ State: _____ Zip: _____

Years at this address: _____

Phone Home: ( ) _____ Other: ( ) _____

Email (for appointment reminders): _____

If patient is a minor, who is legally responsible? _____

Employer: _____ Number of Years Employed: _____

Social Security Number: _____-_____-_____ Birthday: _____-_____-_____

Spouse;s Name: _____ Relationship to Patient: _____

Employer: _____ Number of Years Employed: _____

Social Security Number: _____-_____-_____ Birthday: _____-_____-_____

In case of emergency, who should we contact? _____

Phone: ( ) _____ Relationship: _____

Who may we thank for referring you? _____

Dental Insurance Information

Primary Dental Insurance:

Name of Insurance Company: _____ Phone: ( ) _____

Insurance Address: _____

Subscriber's Name: _____ SSN or Sub ID: _____

Date of Birth: _____-_____-_____ Group or Policy Number: _____

Secondary Dental Insurance:

Name of Insurance Company: _____ Phone: ( ) _____

Insurance Address: _____

Subscriber's Name: _____ SSN or Sub ID: _____

Date of Birth: _____-_____-_____ Group or Policy Number: _____

GARFINKLE ORTHODONTICS
HIGH TECH HIGH TOUCH

Health History

Form Completed By: _____

Are you presently under the care of a physician? Yes No

If yes, for what conditions: _____

_____

Name of Physician: _____ Phone: ( ) _____

In the last five years, have you ever been:

Hospitalized	No	Yes
Had a serious illness	No	Yes
Had a major operation	No	Yes

Have you ever had, or do you presently have any of the following conditions?

Heart Surgery, Heart Disease, or Heart Attack	Yes	No	Thyroid Disease	Yes	No
Angina Pectoris/Chest Pain	Yes	No	Ulcer	Yes	No
High/Low Blood Pressure	Yes	No	AIDS or HIV positive (STDs)	Yes	No
Heart Murmur	Yes	No	Hepatitis, Jaundice, or Liver Disease	Yes	No
Rheumatic Fever/Rheumatic Heart Disease	Yes	No	Blood Transfusion	Yes	No
Congenital Heart Lesions/Mitral Value Prolapse	Yes	No	Drug Addiction/Alcoholism	Yes	No
Artificial Heart Valve	Yes	No	Hemophilia or Excessive Bleeding	Yes	No
Heart Pacemaker	Yes	No	Use of Fen-Phen, Redux, or diet pills	Yes	No
Artificial Joint/Prosthesis	Yes	No	Use of Coumadin or blood thinners	Yes	No
Stroke	Yes	No	Organ Transplant	Yes	No
Kidney Disease	Yes	No	Psychiatric Treatment	Yes	No
Cancer or Tumors	Yes	No	Allergies/Hay Fever	Yes	No
Radiation Treatment of the Head or Neck	Yes	No	Asthma	Yes	No
Lung Disease/Tuberculosis	Yes	No	Sinus Trouble	Yes	No
Diabetes	Yes	No	Seizures/Epilepsy	Yes	No
Jaw Joint (TMJ) Problems	Yes	No	Arthritis	Yes	No
			Osteoperosis	Yes	No

Have you ever had an allergic or unusual reaction to any of the following?

Latex Materials	Yes	No
Penicillin	Yes	No
Erythromycin or Other Antibiotics	Yes	No
Sulfa Drugs	Yes	No
Nickel	Yes	No
Any Other Medication or Drugs	Yes	No

Which Ones? _____

Women: Are you Pregnant? Yes No If Yes, How Many Months? _____

Please list any medications (over the counter or prescription) that you are now taking:

_____

_____

If you have ever had any serious complications involving dental treatment, please explain:

_____

_____

GARFINKLE ORTHODONTICS
HIGH TECH HIGH TOUCH

Dental History

Family Dentist: _____

Date of your last visit to this dentist: _____

How many times per day do you ***BRUSH*** your teeth? 0 1 2 3+

How many times per day do you ***FLOSS*** your teeth? 0 1 2+

History of:			Specifics of Problem If ***Yes***:	Please explain all ***Yes*** answers:
Tooth Injury	No	Yes	Chipped / Broken / Lost	_____
Jaw Injury	No	Yes	At Age: _____	_____
Oral Disease	No	Yes	Ulcers / Sores	_____
Jaw Joint Pain	No	Yes	Right: Constant / Periodic	_____
			Left: Constant / Periodic	_____
Jaw Joint Noises	No	Yes	Right: Click / Pop / Grating	_____
			Left: Click / Pop / Grating	_____
Jaw Joint Locking	No	Yes	Right: When Open / Closed	_____
			Left: When Open / Closed	_____
Grinding Your Teeth	No	Yes	During Day / When Sleeping	_____
Clenching Your Teeth	No	Yes	During Day / When Sleeping	_____
Bleeding Gums	No	Yes	Brushing / Flossing / Eating	_____
Oral Habits	No	Yes	Thumb Sucking / Finger Sucking / Tongue Thrusting / Nail Biting	
			_____	
Other Oral Problems	No	Yes	_____	
			_____	
Headaches	No	Yes		
Snoring/Sleeping Issues	No	Yes	_____	

Have you ever had:			What kind of treatment?	Doctor seen:
Periodontal (gums) Treatment	No	Yes	_____	_____
Orthodontic (braces) Treatment	No	Yes	_____	_____
Endodontic (root canal) Treatment	No	Yes	_____	_____
Oral Surgery (jaw surgery) Treatment	No	Yes	_____	_____
Prosthodontic (crown & bridge) Treatment	No	Yes	_____	_____

I hereby certify that I have reviewed the above medical history and that it is accurate to my knowledge at this time and that I have also received a copy of this office's Notice of Privacy Practices. If there are any future changes in this information, I will inform this practice of these changes.

_____

Patient Signature (or Guardian) Date

_____

Doctor Signature Date of review

_____

Treatment Coordinator Signature Date of review

GARFINKLE ORTHODONTICS
HIGH TECH HIGH TOUCH

PRIVACY POLICY

I. INTRODUCTION

Recently, the United States Department of Health and Human Services ("HHS") issued comprehensive regulations relating to the privacy of patient records. It is the intent of this office to comply with each of these new rules, and this policy is designed to provide a framework to accomplish this goal. These rules apply to this office because, among other things, we transmit patient records electronically. However, the rules apply to *all* "protected patient information," whether in electronic or paper form, or whether disclosed orally. For purposes of this Privacy Policy, "protected patient information" includes any individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data. Employment records are not included within the definition (and thus not subject to the privacy rule) unless they are used in connection with the provision of employment.

II. PRIVACY OFFICIAL

The Garfinkle Orthodontics Office Manager shall be this office's "privacy official." As such, they shall be responsible for implementing this Privacy Policy, as well as developing any future amendments or revisions to this Policy.

III. CONTACT PERSON

The Garfinkle Orthodontics Office Manager shall be designated as this office's "contact person." He or she shall therefore be responsible for receiving any complaints or inquiries about patient privacy matters, and responding to such complaints or inquiries. The Contact Person shall document all complaints or inquiries received. If any patient or other person desires to make a complaint relating to patient privacy, the Contact Person shall instruct him or her to submit the complaint in writing. The Contact Person shall then investigate the complaint or inquiry, determine a resolution in conjunction with Dr. Garfinkle, and respond to the complainant or inquirer as to the results of the investigation and resolution. If the inquiry is a complaint, the person shall be advised of his/her right to file a complaint with HHS and notified that the complaint must be filed within 180 days of the date of the alleged violation.

IV. PRIVACY TRAINING

This office will routinely undertake privacy training for all staff. The training will occur on an annual basis for all existing staff, unless otherwise changed to a more frequent basis. In addition, all new staff shall participate in privacy training immediately upon their commencement of employment with this office. A written record of this training will be maintained by the Privacy Official.

V. USE AND DISCLOSURE OF PROTECTED PATIENT INFORMATION

A. GENERALLY

No protected patient information shall be used or disclosed in any manner other than in conformity with this Policy. Staff should always be mindful of the need to maintain confidentiality of patients' records and protected health information. Thus, for example, in certain instances it may be appropriate to lower voices or request waiting patients stand a few feet away from patients with whom you are discussing treatment aspects, scheduling appointments, etc. Access to protected patient information shall only be given to the following staff members: Orthodontists, Case Managers, Administrative Staff, Sterilization Technicians, Interns and individuals who are job shadowing.

B. NOTICE AS TO USE AND DISCLOSURE OF PATIENT INFORMATION

The form Notice attached to this Policy shall be given to all patients *at their first appointment*. A copy of the signed and dated Notice must be maintained in each patient's file. The notice may be amended upon approval of Dr. Garfinkle. If the Notice is amended, it must be amended promptly and distributed to all patients who have been given the earlier version(s). No material change to the Notice will be implemented prior to the effective date shown on the revised notice.

C. AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

If Dr. Garfinkle ever determines that protected patient information will be used or disclosed for any purpose other than in connection with treatment, payment or health care operations (defined above), then the patient must sign the form Authorization attached to this Policy. For example, this form would be appropriate where the patient's information will be used to determine whether to hire the patient, making a disclosure of the information to a financial institution, marketing, etc. Special rules apply (and additional items must be included in the form) where Dr. Garfinkle intends to use the protected health information for his own purposes, additional items are requested by Dr. Garfinkle in connection with disclosure by other third parties, or where the use or disclosure relates to research that includes the patient's treatment. A patient will not be refused treatment on the basis of his/her refusal to sign the Authorization form, unless the treatment will be used for research, in which case treatment may be refused at the option of Dr. Garfinkle. A patient may revoke the Authorization in writing at any time. In general, the form Authorization should be reviewed by legal counsel prior to signature by the patient.

D. "MINIMUM NECESSARY" USE AND DISCLOSURE OF PATIENT INFORMATION FOR NON-TREATMENT PURPOSES

Wide latitude is given as to the use or disclosure of patient information for purposes of treatment. Thus, any information that Dr. Garfinkle deems appropriate will be used or disclosed. However, if the use or disclosure of protected patient information occurs for any other reason (i.e., for payment, reimbursement or health care operations, etc.), the information used, disclosed or requested must be limited to the minimum degree necessary to accomplish the purpose for which the use, disclosure or request is made. (Note that this restriction does not apply to uses or disclosures of the information to the patient to whom the information relates.)

E. DISCLOSURES TO SERVICE PROVIDERS

Any disclosure to service providers by this office (i.e., labs, collection agencies, attorneys, accountants, etc.) may only occur after certain safeguards are in place. Namely, there must be a written agreement substantially in the form attached to this Policy prior to the release of any protected patient information. Because there are special rules in the privacy regulations relating to vendors and unique state laws, the attached form should be reviewed by legal counsel prior to signature.

VI. SPECIFIC PATIENT REQUESTS

A. FOR RESTICTIONS ON USE AND DISCLOSURE

Patients may request restrictions on the use and disclosure of their protected health information. However, we are not obligated to honor these requests. But if we elect to honor the request, we must adhere to it. Any denial must be in writing.

B. FOR COMMUNICATION OF THEIR INFORMATION

Patients have the right to request confidential communication of their protected health information. For example, they may request that the information be communicated by alternative means (i.e., sending correspondence to their office rather than to their home). If such a request is made, it should be in writing and we will abide by that request as long as it is reasonable. We are not allowed to inquire as to the reason(s) for the request.

C. FOR INSPECTION AND COPIES OF THEIR RECORDS

Consistent with applicable ethics rules of the American Association of Orthodontists and the new privacy rules, we will provide patient records to them or their designee at any time for a duplication fee of $25 (not including x-rays and study models). An additional fee will be required for x-rays and study model duplication. However, special permission from Dr. Garfinkle must be obtained prior to releasing the information if the information is compiled in anticipation of, or for use in, litigation or administrative (i.e., dental board) proceedings. (The new privacy rules do not require that the information be provided to the patient in those instances.) Any denial must be in writing. We have 30 days after receiving a request for access or copies from a patient within which to provide the access or information, unless the data is maintained off-site, in which case we have 60 days from the date of the request. A 30-day extension may be obtained if, within the initial 30-day period, we provide written notice to the patient of the reasons for the delay and give a date on which we will provide a response.

D. TO ADMEND OR MODIFY THEIR HEALTH INFORMATION

From time to time, patients may request that their protected health information be modified. Generally, we will honor their requests. However, such requests will not be honored if the information is accurate and complete, or if we did not create the information. If we honor the request, we must obtain a list of persons or entities that the patient wants us to inform of the amendment from the patient, along with the patient's authorization to inform them. We must then undertake reasonable efforts to notify those persons or entities of the amendment. If we deny the request, the denial must be in writing and advise the patient of (1) the reasons for the denial, (2) their right to submit a "written disagreement", (3) his/her right to ask that the request to amend and our denial be included with any future disclosure of the subject information if not "written disagreement" is submitted, and (4) his/her right to file a complaint with the HHS Secretary. We must respond to any request to amend health information within 60 days of receiving the request. An additional 30 days is allowed if, within the original 60-day period, we notify the patient of the reason(s) for the delay and provide a date on which we will provide a response.

E. FOR AN ACCOUNTING OF DISCLOSURES

If requested and unless an exception exists, we will provide patients with a written accounting of all disclosures of their protected health information that we have made for the period requested, but not to exceed six years from the date of the request. Unless decided otherwise by Dr. Garfinkle, we will not provide disclosures relating to the following: 1. Treatment of the patient, including disclosures made to other treatment providers (i.e., their general dentist, periodontist, etc.); 2. Payment by or on behalf of the patient; 3. Health Care Operations (i.e., information disclosed in connection with performance reviews, training, certification, accreditation or licensing); 4. Disclosures made to the patient or those involved in the care of the patient; 5. Incidental disclosures (i.e., from sign-up sheets, overheard conversations, etc.); 6. Any disclosures that occurred pursuant to an Authorization signed by the patient; or, 7. Any disclosures that occurred prior to April 14, 2003. We must respond to a patient's request for an accounting of disclosures within 60 days of the request. We can obtain an additional 30 days to respond by, within the initial 60-day period, providing the patient with written notice of the reason(s) for the delay and giving a date on which a response will be provided. Patients are entitled to one free accounting within a 12-month period. Any further requests for an accounting of disclosures may involve a reasonable fee, which will be determined by Dr. Garfinkle on a case-by case basis.

VII. VIOLATION OF PRIVACY POLICY

Any violation of this Privacy Policy shall be grounds for discipline, including termination. Compliance with this Policy is required in addition to all other office personnel policies, if any.