ARTHUR L. (SKIP) HUDSON D.D.S., M.S. Adult___ Young Adult___ Child___ Male___ Female___
428 ARDEN AVENUE, #101 GLENDALE, CA 91203

ACCOUNT# PATIENT INFORMATION MODEL#

Date______________________ Appointment Date ______________________

Patient's Name ____ Nickname__________________________
(Last) (First) (Middle)

Address____ Height________ Weight_________
(Street) (City) (State) (Zip)

Home Phone__________________________ Cell Phone ________________________ Birth Date_____________________ Age_________

Grade__________ School___________________________ City________________________ Who Referred___________________________

Hobbies/Sports____ Social Security No.___________________

Family E-mail ____

Emergency Contact _________________________________ Relation ___________________________ Phone ______________________

RESPONSIBLE PARTY INFORMATION MUST COMPLETE *

Name ____ Marital Status_________________________________
(Last) (First) (Middle)

Address ____
(Street) (City) (State) (Zip)

Mailing Address____
(Street) (City) (State) (Zip)

Cell Phone ___________________________________

*Social Security No.______________________________ *Birth date______________________ *Relation to patient _______________________

*Employer___________________________________ *Occupation___________________________ *No. Years Employed _______________

*Spouse's Name _______________________________________ *Spouse's Employer's ____

*Occupation____ *Employer's Address ____

*Social Security No._______________________________ *Birth date_______________________ *Cell Phone__________________________

Got Insurance? We would be happy to process your orthodontic claim… free of charge.
We only require an insurance card copy or a fully completed claim form.

DENTAL INSURANCE INFORMATION PEL SENT_________PGL SENT_________

Insured's Name____ Insured's Social Security No.________________________

Insurance Co.___________________________________ Group_______________________________ Policy No.______________________

Insurance Co. Address____ Phone No.______________________

Insured's Employer & Address____ Phone No.______________________

Do you have dual coverage? _____________________________ If yes: ____

Insured's Name____ Insured's Social Security No. __________________________________

Insurance Co.____ Group____________________________ Policy No.___________________

Insurance Co. Address____ Phone No._____________________________

Insured's Employer & Address____

PLEASE TURN OVER & COMPLETE BACK PAGE

Physician____ Date of last visit____________________

Address____ Phone ____________________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? ____

Yes No Are you allergic to any medication? Latex or nickel? ______________________________

Yes No Do you have a history of a major illness? ______________________________________

Yes No Have you had any major operations? ____

Yes No Have you ever been involved in a serious accident? ____________________________

Circle any of the medical conditions below that you have had or currently have.

Abnormal Bleeding	Cerebral Palsy	Gastrointestinal disorders	HIV-AIDS	Rheumatic Fever
ADD/Autism	Congenital Heart Defects	Heart Problems	Kidney Problems	Severe/Frequent Headaches
Anemia	Diabetes	Heart Murmur	Nervous Disorders	Sinus Problems
Arthritis	Dizziness	Hepatitis/Liver Problems	Pneumonia	STD's
Asthma/Hay fever	Drug/Alcohol Problems	Herpes	Prolonged Bleeding	Tuberculosis
Bone Disorders	Epilepsy	High Blood Pressure	Radiation/Chemotherapy	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? ____________________

DENTAL HISTORY

Dentist____ Date of last visit ____________________

Address____ Phone____________________________

What concerns you most about your teeth?____

Please circle Yes or No (If Yes, Please fill in details)

Yes No Are you presently in any dental pain? ______________________________________

Yes No Have you ever experienced any unfavorable reaction to dentistry? ____________________

Yes No Have you ever lost or chipped any teeth? ____________________________________

Yes No Have there been any injuries to your face, mouth or teeth? _________________________

Yes No Is any part of your mouth sensitive to temperature or pressure? ______________________

Yes No Have you had your tonsils/adenoids removed? _________________________________

Yes No Are there any breathing problems that you are aware of? (Mouth breather) ______________

Yes No Do your gums bleed when you brush? _______________________________________

Yes No Do you have any type of thumb or tongue habit? ______________________________

Yes No Have you ever seen an orthodontist? If yes, who and when? ________________________

What is your attitude toward receiving orthodontic treatment? ________________________

Yes No Has anyone in your family received orthodontic treatment? _______________________

How did they feel about the result? ____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?______________

Yes No Are you aware of your jaw clicking or popping? ________________________________

Yes No Are you aware of clenching your teeth during the day? ___________________________

Yes No Have you ever been told that you grind your teeth? ______________________________

Yes No Do you have "tension" headaches? ____

Yes No Have you ever experienced chronic ringing in your ears? __________________________

If the patient is under age 16, height of parent? Mom ____________________ Dad____________________

Yes No Are you aware that some appointments will be during school/work hours? ________________

Female Patients only:

Yes No Are you pregnant? ____

Yes No Has menstruation started? ____

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any dentist, physician, medical practitioner, hospital, clinic, any dental or medically related facility to release any information available to help us with diagnosis and prognosis of my or my child's case. Information obtained by use of this authorization will not be released by Arthur L. Hudson, D.D.S., M.S. without my express permission. I understand where appropriate, credit bureau reports may be obtained.

Signature of Patient or Legal Guardian ____ Date____________________

TO THE BEST OF MY KNOWLEDGE, ALL OF THE ANSWERS ON THE FRONT & BACK SIDE OF THIS FORM ARE TRUE AND CORRECT. IF EVER THERE IS A CHANGE IN HEALTH, OR ANY MEDICATION CHANGE, I WILL INFORM DR. HUDSON.

Signature of Patient or Legal Guardian ____ Date____________________

**************** **FOR OFFICE USE** ****************

MIDLINE

R **L**

Date______________________________

Assistant___________________________

X-rays taken?________________________

Case #_____________________________

Lab_______________________________

Due Date___________________________

OCCLUSAL PLANE

R **L**

NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

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

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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 and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by

presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting disclosure of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of ____________________, 20____and we are required to abide by the terms of the Notice of Privacy currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPPA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement

Arthur (Skip) L. Hudson, D.D.S., M.S.
A Professional Corporation
Orthodontist
428 Arden Ave, Suite 101
Glendale, California 91203
Telephone (818) 244-2121
Fax (818) 244-1956

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

SIGN HERE

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason