PATIENT NAME_____ GENDER M or F BIRTHDATE ____/____/____

ADDRESS_____ CITY_____ STATE____ ZIP_____

PHONE_____CELL_____ EMAIL_____

EMPLOYER _____ SS# _____-_____-_____

MARITAL STATUS - SINGLE MARRIED DIVORCED SPOUSE'S NAME_____

SPOUSE'S BIRTHDATE ____/____/____ SS# ____-____-_____ SPOUSE'S EMPLOYER_____

DENTIST_____ REFERRED BY DENTIST? YES NO OTHER_____

HAVE YOU SEEN AN ORTHODONTIST BEFORE? YES NO IF SO, WHEN_____

MEDICAL HISTORY

1. HAS YOUR GENERAL HEALTH BEEN .... GOOD AVERAGE POOR

2. ARE YOU UNDER MEDICAL CARE NOW? _____ FOR? _____

   LIST ANY MEDICATIONS _____

   ALLERGIC TO ANY MEDICATION YES NO IF SO, WHAT?_____

3. PREGNANT? N/A NO YES DUE DATE _____

4. PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE EXPERIENCED

ASTHMA	DIABETES	HEPATITIS B	SEVERE FACIAL INJURY
ANEMIA	EPILEPSY	HEPATITIS C	TUBERCULOSIS
BLOOD DISEASE	ENDOCRINE PROBLEMS	LATEX ALLERGY	VASO-VAGAL SYNCOPE
BONE DISORDER	EMOTIONAL PROBLEMS	POLIO	FOOD ALLERGY
CONVULSIONS	HEART DISEASE	REPEATED HEADACHES	NICKEL ALLERGY
CJD	HEARING DISORDER	RHEUMATIC FEVER	

* PLEASE COMPLETE OTHER SIDE *

5. Please check all that apply:

___ allergies that affect breathing
___ snoring
___ breathe through the mouth when awake
___ breathe through the mouth when asleep
___ frequent sore throats or tonsillitis
___ chewing or swallowing difficulty
___ pain or clicking in the jaw
___ serious problems with cavities or gums
___ speech therapy
___ any teeth removed by a dentist
___ tonsils and adenoids removed? If so, when_____
___ congenitally missing teeth
___ impacted teeth
___ jaw discrepancies

6. Please circle any of the following habits you have now or have had in the past.

Thumb sucking	Pencil biting	Nail Biting
Finger sucking	Grinding of teeth	
Lip Biting or Sucking	Tongue Thrusting	

7. Do you play a musical instrument? YES NO If so, which one?_____

8. In what sports do you participate?_____

By signing below I authorize the release of any information to my insurance provider to generate payment and for this practice to receive payment directly. I understand and agree that I am financially responsible for the balance on my account regardless of insurance status. If this account should become delinquent I understand that I will be held responsible for any and all costs, late charges, and additional fees that may be incurred in collection efforts.

SIGNATURE OF RESPONSIBLE PARTY _____DATE_____

DENTAL INSURANCE INFORMATION

PATIENT NAME _____ BIRTHDATE_____

PRIMARY DENTAL INSURANCE

POLICY HOLDER NAME_____ RELATIONSHIP TO PATIENT_____

ADDRESS _____ Phone#_____

POLICY HOLDER BIRTHDATE _____ SS# _____-_____-_____

EMPLOYER_____ ID#_____

INSURANCE COMPANY _____ INSURANCE CO. PHONE #_____

INSURANCE CO. ADDRESS_____

GROUP/POLICY#_____

Office use only: max $_____ @_____% Remaining_____ age_____ effective_____

SECONDARY DENTAL INSURANCE

POLICY HOLDER NAME_____ RELATIONSHIP TO PATIENT_____

ADDRESS _____Phone#_____

POLICY HOLDER BIRTHDATE _____ SS# _____-_____-_____

EMPLOYER_____ ID#_____

INSURANCE COMPANY _____ INSURANCE CO. PHONE #_____

INSURANCE CO. ADDRESS_____

GROUP/POLICY#_____

Office use only: max $_____ @_____% Remaining_____ age_____ effective_____

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO BURTON L. HAGLER DDS MS INC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT.

SIGNATURE OF PATIENT/GUARDIAN_____ **DATE**_____

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, however, we do not transmit patient records electronically. The rules apply to *all* "protected patient information," whether in electronic 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 included within the definition (and thus not subject the privacy rule), unless they are used in connection with the provision of employment.

II. PRIVACY OFFICIAL

Diane Ashworth shall be this office's "privacy official." As such, she shall be responsible for implementing this Privacy Policy, as well as developing any future amendments or revisions to this Policy.

III. CONTACT PERSON

Diane Ashworth shall be this office's "contact person." 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. Hagler, 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.

A COPY OF OUR PRIVACY POLICY IS POSTED IN OUR OFFICE AND AVAILABLE UPON REQUEST.

I HEREBY ACKNOWLEDGE THAT I HAVE READ A COPY OF THE PRIVACY POLICY.

_____ _____

PATIENT/GUARDIAN DATE

_____

PRINT PATIENT NAME