INFORMACION DEL PACIENTE

Fecha____________________

Nombre de paciente ____
Apellido Primero Segundo

Fecha de nacimiento________________ Edad_______ Sexo M F No. Seguro Social ______________________________

Direccion ____
Calle Ciudad Codigo postal

Tel. casa_________________________ Tel. trabajo________________________ No. Celular______________________________

A quien debemos agradecer por referirle? ____

Si es menor, Escuela _____________________ Grado __________ Hobby____

CONTACTO DE EMERGENCIA: Familiar mas cercano que no vive con usted___________________ No. tel. _________________

INFORMACION DE LA PERSONA RESPONSABLE

Nombre ____
Apellido Primero Segundo

Direccion ____ Tel. casa__________________________________

Tel. trabajo___________________ Cel. / otro _________________________ Correo electronico ____________________________

No. Seguro Social _____________________Fecha de nacimiento__________________ Relacion con el paciente ________________

Empleador______________________________________ Ocupacion____________________ No. de años empleado______________

Nombre de su pareja____ Relacion al paciente ____________________________

Empleador______________________________________ Ocupacion____________________ No. de años empleado______________

No. Seguro social _______________________________ Fecha de nacimiento ___________Tel. trabajo ______________________

INFORMACION DE SU ASEGURANZA DENTAL

Nombre del asegurado____________________________________ Seguro social del asegurado ______________________________

Compañia de aseguranza________________________ Grupo No._________________ Tel. Local _____________________________

Direccion de la aseguranza____ No. telefono.__________________________

Tiene doble cobertura? Si_____ No: _______ Si tiene doble cobertura, por favor responda las siguientes preguntas:

Nombre del asegurado____________________________________ Seguro social del asegurado ______________________________

Compañia de aseguranza________________________ Group No._________________ Tel. Local _____________________________

Direccion de la aseguranza____ No. telefono.______________________________

HISTORIA MEDICA

Medico____ Fecha de su ultima cita_________________________

Direccion____ Telefono________________________________

Por favor circular (Si contesta si para alguna pregunta, por favor llene los detalles)

Si No Toma algun medicamento (incluyendo bifosfonatos)? ____
Si No Ha tenido alguna enfermedad grave?____
Si No Ha tenido alguna operacion o cirugia?____
Si No Alguna vez ha tenido un accidente serio?____
Si No Ha visitado su medico general en los ultimos 12 meses? Porque?____
Si No Fuma?

Revised: April 2, 2018

Para las pacientes femeninas solamente:
Si No Ya empezo su menstruacion? Hace cuanto? Años/Meses______________
Si No Esta embarazada ? No. de semanas _____________________

Alergias (Por favor circular)
Penicilina Anestecia Local Latex Comida___________________
Medicamentos/Drogas ______________________________________ Otros ____________________

Por favor circular la(s) condicion(es) medica(s) abajo mencionada que tenga o haya tenido .

Sangrado Abnormal /Hemofilia	Diabetes	Hepatitis/Problemas del riñon	Neumonia
Anemia	Mareos	Herpes	Sangrado prolongado
Artritis	Epilepsia	Presion alta	Radiacion/Quimoterapia
Asma o Fiebre del heno?	Trastorno Gastrointestinal	VIH / SIDA	Fiebre reumática
Problemas de sinusitis	Problema cardiaco	Problemas Renales	Tuberculosis
Trastorno de los huesos	Soplo cardiaco	Desorden nervioso	Tumor o Cancer
Abuso de drogas/Alcohol	Defecto cardíaco congénito		

Existe alguna condición médica que no hayamos mencionado, que usted crea que debemos saber?
____

HISTORIA DENTAL

Dentista General ____ Fecha de su ultima visita______________________________

Qué le preocupa más acerca de sus dientes? ____

Si No Tiene algun dolor dental?____
Si No Alguna vez has experimentado alguna reaccion desfavorable donde su dentista?________________________
Si No Alguna vez a sufrido una lesion/golpe/trauma en la cara, boca o los dientes? ____________________________

Cuantas veces al dia se cepilla los dientes? ___________________________ Usa hilo dental?______________________________

Habitos (Por favor circular)

Habito de chupar dedo Empuje lingual Habito de chupar el labio Morder uñas Respirar por la boca

Articulación temporomandibular - ATM (Por favor circular)

Dolor articular o de los maxilares Sonido o brinco de la articulacion Apreta sus dientes durante el día/noche

Entiendo que algunas citas serán en horas de escuela/trabajo y que mis registros de diagnóstico y mi nombre pueden ser usados para propósitos educativos y promocionales..

Por favor indique si da permiso a Rendon Orthodontics de incluir fotos, videos e informacion suya o de su hijo/a en las paginas de Facebook, YouTube, etc. Si_____ No_____ Iniciales________

Autorizo a el Dr. Juan Rendon y/o a la Dra. Maria Castano-Rendon para realizar una evaluación de ortodoncia completa. Tambien autorizo a los doctores y a sus asistentes para llevar a cabo los servicios necesarios de ortodoncia que necesite durante el tratamiento.

Autorizo a OrthoBanc, LLC por medio del Dr. Juan Rendon y/o de la Dra. Maria Castano-Rendon, para obtener mi reporte de credito con las entidades correspondientes, con el proposito de considerer opciones de pago.

He contestado honestamente y he entendido todas las preguntas. Informare a esta oficina de cualquier cambio en mi historia médica o dental.

Firma____ Fecha ___________________________________

Firma - Informacion actualizada____ Fecha_______________________________

Patient copy

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 YOUR 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 4/1/2003, 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 make 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 or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or 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 disclosures permitted by your authorization while it was in effect.

To Your Family, Friends and Persons Involved in Care: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your 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. 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 your care, 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 pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Court Orders and Subpoenas: We may disclose information in response to an appropriate court order or subpoena.

Law Enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably 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). We may also contact you to provide information about treatment alternatives or other health-related information that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. 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.

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 your 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 or 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 your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Frisco Office
12398 FM 423, Suite 100
Frisco, TX 75033
Telephone: (972) 377-8844
Fax: (972) 377-8840
info@rendonorthodontics.com

Allen Office
705 S. Custer Rd, Suite 130
Allen, TX 75013
Telephone: (972) 649-7900
Fax: (972) 649-7906
allen@rendonorthodontics.com

Revised: April 2, 2018

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

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)

____
____

Witness: ____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ___________________________________ Minor Patient Name ___________________________________
Address: ____
Telephone: _____________________________________ E-mail: ____
Patient Number: _________________________________ Social Security Number: ____________________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Frisco Office: 12398 FM 423, Suite 100 Frisco, TX 75033 Telephone: (972) 377-8844 Fax: (972) 377-8840
Allen Office: 705 S. Custer Rd, Suite 130 Allen, TX 75013 Telephone: (972) 649-7900 Fax: (972) 649-7906

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to either of our offices listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____ Date: ____________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: __________________________________Relationship to Patient: ________________

REVOCATION OF CONSENT

I revoke my Consent for use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____Date:_____________________________