Runnels Orthodontics

Welcome to our practice! At Runnels Orthodontics our main goals are to support our locals to our fullest capabilities, provide efficient and thorough orthodontic treatment, and make people truly smile by their end results.

At your New Patient consultation we will be using advanced 3D technology to analyze and simulate your customized treatment plan.
Dr. Runnels has set aside 45 minutes to provide you with the highest quality examination and a program that best enhances your smile.

Again, our team would like to welcome you to our family! If you ever have any questions you may contact us by texting 850-470-1566, calling 850-252-8139, or visiting our website www.runnelsortho.com!

Attached below are our 3 office locations.

Patient Information:

Date:_____

Patient's Full Name:_____ Nickname:_____

Male__ Female__ Age___ Date of Birth_____ Contact #_____

Email_____ Dentist_____

How Did You Hear About Us?_____

Reason for Consultation:_____

If patient is adult:

Address_____ Zip Code_____

Employer Name/Address_____

Spouse's Full Name_____ Contact #_____

If patient is a child:

School_____ Grade_____

Father's Name_____ Mother's Name_____

Parent's Marital Status: Single Married Divorced Patient Lives With_____

Home Address_____ Zip Code_____

Father's Employer_____ Contact #_____

Mother's Employer_____ Contact#_____

Insurance Information (If Applicable):

Insurance Company_____ Contact #_____

Address_____ Policy Holder's Name_____

DOB_____ SSN/ID#_____ Employer_____

Medical Conditions

Please circle any of the following for which the patient/you have a history.

AIDS/HIV	**Cancer**	**Difficulty Breathing**	**Fainting/Dizziness**	**Muscular Disorders**
Allergies	**Cerebral Palsy**	**Down Syndrome**	**Headaches**	**Nervous Disorders**
Anemia	**Chest Pains**	**Drug Allergies**	**Heart Condition**	**Perio Problems**
Arthritis	**Chronic Neck Pain**	**Emphysema**	**Hepatitis**	**Prolonged Bleeding**
Asthma	**Clicking of Jaw**	**Emotional Disorders**	**High/Low BP**	**Psychiatric Treatment**
Bone Disorders	**Cold Sores/Herpes**	**Endocrine Problems**	**Immune Problems**	**Rheumatic Fever**
Bulimia	**Diabetes**	**Epilepsy/Seizures**	**Kidney Problems**	**Scoliosis**

Current Medications_____

Allergies to: Latex - Aspirin - Metals/Plastics - Codeine - Erythromycin - Penicillin - Other

Females: At what age did menstruation start?_____ Are you trying/currently pregnant?_____

Have wisdom teeth been extracted?_____ Any face, mouth, or teeth injuries?_____

Are there any missing teeth? _____ Do gums bleed when flossed?_____

Have tonsils and adenoids been removed?_____ Have you previously had orthodontic treatment?____

Signature_____**Date**_____

Print Name_____

HIPPA

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.

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic date) may be used or disclosed by us, electronically or physically, in one or more of the following respects:

-To other health care providers (i.e. general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e. phone, email, or fax)

-To third party payors or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account;

-To certifying, licensing and accrediting bodies (i.e. the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure, or accreditation;

-Internally, to all staff members who have any role in your treatment;

-To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;

-To other patients, or prospective patients, in print or electronic form for marketing purposes, limited to photos, first names, ages, and basic treatment information;

-To your family and close friends involved in your treatment; and/or

-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 or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

-Request restrictions in the use and disclosure of your protected health information (PHI);

-Request confidential communication of your PHI;

-Inspect and obtain copies of your PHI through asking us;

-Amend or modify your PHI in certain circumstances;

-Receive an accounting of certain disclosures made by us of your PHI; and,

-You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or in the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

-By law, to maintain the privacy of protected health information (PHI) and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;

-To abide by the terms of our Privacy Notice that is currently in effect; and,

-To advise you of your right to change the terms of the Privacy Notice and to make the new notice provisions effective for all PHI maintained by us, and that if we do so, we will make available to you a copy of the revised Privacy Notice.

Please note that we are not obligated to:

-Honor any request by you to restrict the use or disclosure of your PHI

-Amend your PHI if, for example, it is accurate and complete; or

-Provide an atmosphere that is totally free of the possibility that your PHI may be incidentally overheard by other patients or third parties.

This Privacy Notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask our Privacy Contact Person or direct your questions to that person at our office address. Thank you.

Patient Acknowledgement

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice:

Patient/Parent Signature_____ **Date:** _____

HIPPA RELEASE FORM

RUNNELS ORTHODONTICS

I, _____authorize the release of information on _____, including the diagnosis, records, examination and treatment rendered to the above patient, ledger and billing, and claims information.

The information may be released to (check all included)
( ) Step parents: _____
( ) Grandparents: _____
( ) Child care providers: _____
( ) Other: _____
( ) Information is not to be released to anyone. (Initial Here): _____

In further consideration for this, Runnels Orthodontics agrees to the same stipulations. This Release of Information will remain in effect until terminated by me in writing.

Divorce Case: Responsibility for the financial contract can only be with ONE Responsible Party

- ❑ Mother
- ❑ Father
- ❑ Down payment_____
- ❑ ACH Monthly auto draft_____
- ❑ Downpayment and Monthly Auto Draft
- ❑ Signature needed before delivery of appliance

Responsible Party Name_____

Messages and communication from our office:
If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:
( ) you may leave a detailed message
( ) please leave a message asking me to return your call
( ) other _____

The best phone number to reach me at is: _____

Signed: _____Date: __/__/__
Witness: _____Date: __/__/__