John M. Sparaga, D.M.D.

Temporomandibular Joint Disorders, Orofacial Orthopedics, Surgical Orthodontics.
PLEASE COMPLETE PRIOR TO INITIAL APPOINTMENT

Date **Patient#**

Please complete the following personal information and bring to your Initial Exam:

Patient's Name_____ Date of Birth_____ Age_____Sex_____
Last, First and Middle Initial

Mailing address_____City_____ State_____Zip_____

Residence _____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____ Occupation & Employer_____

Employer Phone _____ Employer Address_____ Years of Employment_____

State _____ Drivers License # or ID #_____Social Security No._____

Patient's Dentist_____ Physician_____ Oral Surgeon_____

How did you hear about us? (Circle all that apply) Dentist Friend (Name)_____ Family Member Groupon

Returning Patient Clear Smiles Alaska Website Invisalign Website Facebook Google Other_____

What are your concerns about your teeth/smile/bite? _____

IF PATIENT IS MARRIED, COMPLETE THIS PORTION

Name of Spouse_____Occupation_____Social Security No._____

Employer_____Work Phone_____

Business Address_____

IF PATIENT IS A MINOR (UNDER 18), COMPLETE THIS PORTION

Father's Name_____ Mother's Name_____

Occupation_____ Occupation_____

Employer_____ Employer_____

Work Phone_____ Work Phone_____

Social Security No._____ Social Security No._____

Date Of Birth_____ Date Of Birth_____

License Number_____ License Number_____

BILLING INFORMATION

Billing Party_____ Relationship to Patient_____ Home Phone_____

Address_____City_____State_____Zip_____

Employer _____ Address _____ Work Phone _____

HEALTH QUESTIONNAIRE

Please answer each question. Circle **Yes** or **No** where applicable.

MEDICAL HISTORY

1. Is patient in good health?..... Yes No
2. Is patient presently under the care of a physician?.....Yes No
   If yes, what condition is being treated?_____
3. Has patient ever had any serious illness or operation?.....Yes No
   If yes, what illnesses or operations?_____
4. Is patient taking any drugs or medication?.....Yes No
   If yes, what?_____
5. **Does patient have any allergies?**.....**Yes No**
   If yes, please list_____
6. Does patient use tobacco products?.....Yes No
   If yes, please indicate type and frequency _____
7. Does patient have tendency to colds, sore throats, ear infections?.....Yes No
8. Has patient reached puberty?.....Yes No
   Menstruated (girls) age_____ or voice changed (boys) age_____
9. Does patient have, or ever had any of the following: (Please circle known conditions)

Acquired Immune Deficiency	Difficulty in Swallowing	Herpes	Rheumatic Fever
Allergies	Epilepsy or Seizures	High Blood Pressure	Sinus Trouble
Anemia	Excessive Bleeding	Kidney Disease	Stomach Ulcers
Arthritis or Rheumatism	Fainting Spells	Mental Disorders	Stroke
Artificial Prosthesis (Implants)	Glaucoma	Nervous Disorders	Tuberculosis
Asthma	Hay Fever	Radiation Treatment of any kind	Tumors or Growths
Blood Diseases	Head Injuries	Respiratory Disease	Venereal Disease
Cancer	Heart Ailments	Other _____	
Diabetes	Hepatitis, Liver Disease	_____	

10. Does patient have any disease, condition, or problem not listed?.....Yes No
    If so, please explain:_____

DENTAL HISTORY

1. **Date of last dental examination:**_____
2. **Is dental work complete?**.....**Yes No**
3. How often does patient brush teeth?_____Floss?_____
4. Has patient ever had an injury to face or jaw?.....Yes No
5. Is patient aware of tooth grinding or clinching habits?.....Yes No
6. Does the patient's jaw make "clicking or popping" sounds while chewing?.....Yes No
7. Does patient have any speech problems?.....Yes No
8. Does patient breathe mostly through the mouth, and/or are lips usually parted?..... Yes No
9. Has patient ever sucked a thumb or finger?..... Yes No
   If yes, until what age?_____
10. Does orthodontic/dental treatment make the patient nervous?.....Yes No
    If yes, please circle: slightly moderate extremely

TERMS & CONDITIONS

As a condition of the patient's treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Patients who carry orthodontic insurance understand that all orthodontic services furnished are charged directly to the person who is personally responsible for payment of orthodontic services. If requested, we will supply the billing party with a receipt/pre-authorization/itemized statement for orthodontic/temporomandibular joint initial examination/records treatment. This orthodontic office cannot render services on the assumption that our charges will be paid by an insurance company.

The undersigned understands that the fee estimate listed for this orthodontic case can only be extended for a period of 30 days from the date of the patient's examination. In consideration of the professional services rendered to the patient by the Doctor and/or his staff, the undersigned agrees to pay the value of said services to said Doctor, or his assignee, at the time said services are rendered, or within the agreed upon treatment fee schedule. Additionally, the undersigned agrees that once the treatment contract has been signed and the treatment officially begun, missed appointments or failure to show does not constitute a cancellation of services, and payments according to the payment schedule are due and payable until the account balance is paid off entirely. The undersigned further agrees to pay all costs and attorney fees associated with any and all cases on their behalf. The undersigned grants permission to Clear Smiles Alaska to telephone the patient or billing party at home or work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signed:_____ **Date**_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You May Refuse to Sign This Acknowlegment.

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Relation to Patient: _____

Signature: _____ Date: _____

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 our Privacy Official. 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.

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)

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Clear Smiles Alaska

John M. Sparaga D.M.D.

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 02/26/2015, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts. 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 your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability; o Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative

means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 with the U.S. Department of Health and Human Services.

Our Privacy Official: Clear Smiles Alaska Administrative Staff
Telephone: (907) 522-5000 Fax: (907) 522-5001
Address: 9500 Independence Drive Suite 1000
Anchorage, AK 99507
Email: clearsmilesalaska@gmail.com