KINGWOOD ORTHODONTICS
Holly Pavlick McIver, DDS, MSD
www.KingwoodOrthodontics.com

You have definitely called the right place! At Kingwood Orthodontics we love creating beautiful and healthy smiles. We pride ourselves on caring for our patients like we would our family. Our goal is to provide you with excellent orthodontic care, superior service, and wonderful treatment results!

Thank you for selecting our office! As our gift to you our new patient exam and consultation are complimentary. This first visit will take about an hour where you will receive a tour of our state-of-the art office and meet our friendly team. We will take digital x-rays and photos. We will perform a thorough examination and review your clinical diagnosis. I'll be sure to explain in detail any treatment recommendations that will best benefit your child (or you).

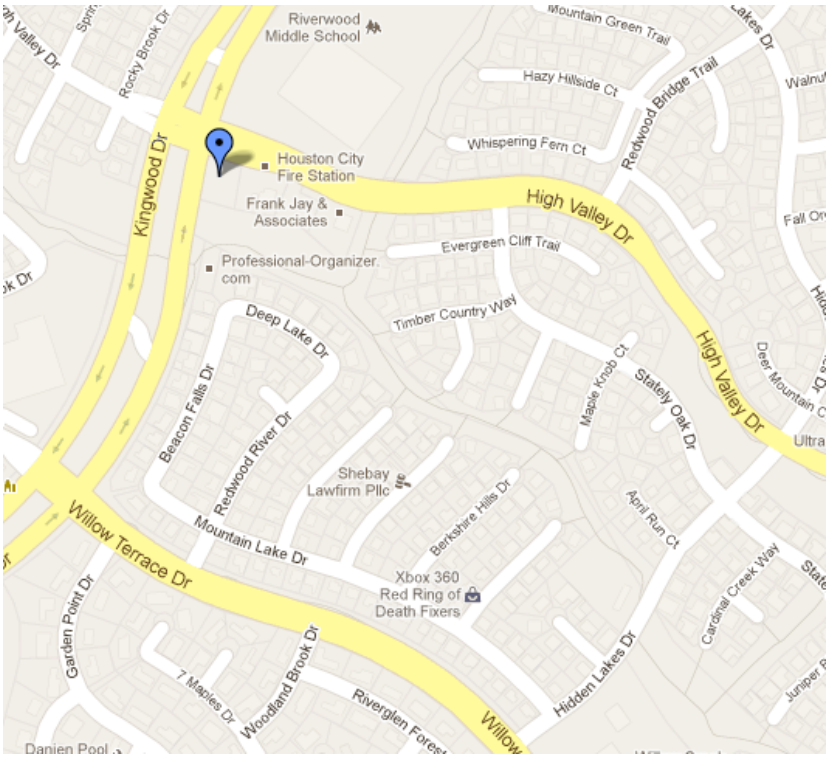
Included with this letter is a new patient questionnaire, health history form, HIPAA privacy notice, and map of our location. Please complete the forms and bring them with you to your appointment.

The entire team at Kingwood Orthodontics is excited about meeting you on for your complimentary consultation. If you have any questions, please give us a call at 281-220-8444.

Welcome to the family!

Sincerely,

Holly Pavlick McIver, DDS, MSD
Orthodontic Specialist
Certified, American Board of Orthodontics



Patient Information:

Patients' Full Name _____ Nickname _____
___ Male___ Female Age _____ Date of Birth _____ Best Phone #_____
Contact Email _____
How do you prefer to receive appointment reminders? (Circle all that apply): **Phone Email**
How may we contact you in regards to your treatment? (Circle all that apply): **Phone Email Fax**
Patient's General Dentist_____ **Date of last visit**_____
Patient's Physician_____

If patient is an adult, please fill out this section:

Home Address _____Zip Code_____
Employed by _____ Bus. Address _____ Phone _____
Spouse's Full Name _____ Employed by _____ Phone _____

If patient is a minor, please fill out this section:

School _____ Grade _____
Father's Name _____ Mother's Name_____
Parents' marital status: Single Married Divorced Patient lives with:_____
Home Address _____Zip Code_____
Father Employed by _____ Bus. Address _____ Phone _____
Mother Employed by _____ Bus. Address _____ Phone _____

Is there any dental insurance we can check for you?..... ____Yes ____No
If yes, list Insurance Company_____ Phone #_____
Policy Holder_____ DOB_____ SSN/ID#_____ Employer_____

List any relatives treated at this office (Name and relation to patient): _____

Patient Health Information and Medical/Dental History:

Have you been under the care of a physician during the past two years? ....____Yes____No
(If so, state condition and duration) _____

Please circle any of the following for which you have experienced, been diagnosed or have been treated for:

Diabetes	**Anemia**	**Pneumonia**	**Asthma**	**Jaw Joint soreness/popping**
Heart Trouble	**Rheumatic Fever**	**Bone Disorders**	**Tuberculosis**	**Severe/FrequentHeadaches**
Epilepsy	**Nervous Disorder**	**Kidney Trouble**	**Endocrine Problem**	**Severe Head/Face Injury**
Fainting or Dizziness	**Hepatitis/Jaundice**	**HIV**	**Prolonged Bleeding**	**High Blood Pressure**
ADD/ADHD	**Autism**	**Other:**_____		

Female Patients...are you pregnant or trying to get pregnant?..... ____Yes _____No
List any medications now being taken _____
List any allergies or drug sensitivities (including Nickel or Latex) _____
Do you experience any type of anxiety during medical or dental appointments?..... ____Yes____No
Have your tonsils or adenoids been removed? (At what age? _____) ..... ____Yes____No
Have you ever sucked your thumb or finger? (Until what age? _____) ..... ____Yes____No
Do you have any speech problems? ..... ____Yes____No
Are you a mouth breather? (Do you snore or frequently wake up in the middle of the night?).... ____Yes____No
Do you play a musical wind instrument? ..... ____Yes____No
Has another orthodontist been consulted previously? ..... ____Yes____No

How did you hear about our office? Website/Internet Friend/Family Dentist/Healthcare Professional Facebook
Whom may we thank for referring you to our office? _____

Signature of Patient, Parent, or Guardian _____ Date _____
Holly Pavlick McIver D.D.S, M.S.D._____Date_____

PRIVACY NOTICE: 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 Name	**Parent/Patient Signature**	**Date**