



EARP DENTISTRY COMPLIES WITH APPLICABLE FEDERAL CIVIL RIGHTS LAWS AND DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, AGE, DISABILITY, OR SEX.

ATENCIÓN: SI HABLA ESPAÑOL, TIENE A SU DISPOSICIÓN SERVICIOS GRATUITOS DE ASISTENCIA LINGÜÍSTICA. LLAME AL 252-756.3313.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 252-756.3313.

2446 EMERALD PLACE  
GREENVILLE, NORTH CAROLINA 27834

363 US HIGHWAY 64  
PLYMOUTH, NORTH CAROLINA 27962

PLEASE TAKE A FEW MINUTES TO ANSWER THE FOLLOWING QUESTIONS  
SO WE CAN BETTER ASSIST YOU WITH YOUR DENTAL NEEDS.

## PATIENT INFORMATION

DATE \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
Last Name First Name Middle Initial

ADDRESS \_\_\_\_\_ CELL PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL \_\_\_\_\_

SEX:  M  F  MINOR  SINGLE  MARRIED  LONG TERM PARTNER  DIVORCED  WIDOWED  SEPARATED

EMPLOYER \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WHO SHOULD WE THANK FOR REFERRING YOU? \_\_\_\_\_

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? \_\_\_\_\_ PHONE \_\_\_\_\_

## PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT \_\_\_\_\_  
Last Name First Name Middle Initial

RELATIONSHIP TO PATIENT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

RESPONSIBLE PARTY EMPLOYED BY \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ OCCUPATION \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

SUBSCRIBER I.D. # \_\_\_\_\_ GROUP # \_\_\_\_\_

## ADDITIONAL INSURANCE

INSURED NAME \_\_\_\_\_  
Last Name First Name Middle Initial

RELATIONSHIP TO PATIENT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURED COMPANY BY \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

SUBSCRIBER I.D. # \_\_\_\_\_ GROUP # \_\_\_\_\_

# DENTAL HISTORY

FORMER DENTIST \_\_\_\_\_

DATE OF LAST X-RAYS \_\_\_\_\_

CITY, STATE \_\_\_\_\_

HOW OFTEN DO YOU FLOSS? \_\_\_\_\_

DATE OF LAST DENTAL VISIT \_\_\_\_\_

HOW OFTEN DO YOU BRUSH? \_\_\_\_\_

PLEASE CHECK ALL THAT APPLY:

- |  |  |   |
|--|--|---|
| BAD BREATH ..... <input type="checkbox"/>                | LOOSE TEETH OR BROKEN FILLINGS .... <input type="checkbox"/> | SENSITIVITY TO SWEETS ..... <input type="checkbox"/>              |
| BLEEDING GUMS ..... <input type="checkbox"/>             | ORTHODONTIC TREATMENT ..... <input type="checkbox"/>         | SENSITIVITY WHEN BITING ..... <input type="checkbox"/>            |
| BLISTERS ON LIPS OR MOUTH ..... <input type="checkbox"/> | PAIN AROUND EAR ..... <input type="checkbox"/>               | FREQUENT HEADACHES ..... <input type="checkbox"/>                 |
| FINGERNAIL BITING ..... <input type="checkbox"/>         | PERIODONTAL TREATMENT ..... <input type="checkbox"/>         | JAW, HEAD OR NECK INJURIES ..... <input type="checkbox"/>         |
| GRINDING TEETH ..... <input type="checkbox"/>            | SENSITIVITY TO COLD ..... <input type="checkbox"/>           | JAW DIFFICULTY: CLICKING AND/ OR PAIN .. <input type="checkbox"/> |
| LIP OR CHEEK BITING ..... <input type="checkbox"/>       | SENSITIVITY TO HEAT ..... <input type="checkbox"/>           | TOOTH PAIN ..... <input type="checkbox"/>                         |

# MEDICAL HISTORY

PHYSICIAN'S NAME \_\_\_\_\_ DATE OF LAST VISIT \_\_\_\_\_

1. ARE YOU CURRENTLY UNDER MEDICAL TREATMENT? .....  Yes  No
2. HAVE YOU EVER HAD ANY SERIOUS ILLNESSES OR OPERATIONS? .....  Yes  No
3. ARE YOU CURRENTLY TAKING ANY MEDICATION? .....  Yes  No  
PLEASE DESCRIBE: \_\_\_\_\_
4. DO YOU SMOKE? .....  Yes  No
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? .....  Yes  No
6. DO YOU WEAR CONTACT LENSES? .....  Yes  No

7. HAVE YOU HAD ANY ALLERGIC REACTIONS TO THE FOLLOWING: Yes No
- |   |                          |                          |
|---|--------------------------|--------------------------|
| LOCAL ANESTHETICS (EG. NOVOCAINE) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| PENICILLIN OR OTHER ANTIBIOTICS .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| SULFA DRUGS .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| BARBITURATES (SLEEPING PILLS) .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| SEDATIVES .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| IODINE .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| ASPIRIN .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| OTHER .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
8. (WOMAN ONLY) ARE YOU:
- |                                   |                          |                          |
|-----------------------------------|--------------------------|--------------------------|
| PREGNANT? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| NURSING? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| TAKING BIRTH CONTROL PILLS? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE CHECK ALL THAT APPLY:

- |  |  |  |
|--|--|--|
| AIDS ..... <input type="checkbox"/>  | EMPHYSEMA ..... <input type="checkbox"/>             | PACEMAKER ..... <input type="checkbox"/>                 |
| ANEMIA ..... <input type="checkbox"/>  | EPILEPSY ..... <input type="checkbox"/>              | PSYCHIATRIC CARE ..... <input type="checkbox"/>          |
| ARTHRITIS, RHEUMATISM ..... <input type="checkbox"/>                           | FAINING OR DIZZINESS ..... <input type="checkbox"/>  | RADIATION TREATMENT ..... <input type="checkbox"/>       |
| ARTIFICIAL HEART VALVES ..... <input type="checkbox"/>                         | GLAUCOMA ..... <input type="checkbox"/>              | RESPIRATORY DISEASE ..... <input type="checkbox"/>       |
| ARTIFICIAL JOINTS ..... <input type="checkbox"/>                               | HEADACHES ..... <input type="checkbox"/>             | RHEUMATIC FEVER ..... <input type="checkbox"/>           |
| ASTHMA ..... <input type="checkbox"/>  | HEART MURMUR ..... <input type="checkbox"/>          | SCARLET FEVER ..... <input type="checkbox"/>             |
| BACK PROBLEMS ..... <input type="checkbox"/>                                   | HEART PROBLEMS ..... <input type="checkbox"/>        | SHORTNESS OF BREATH ..... <input type="checkbox"/>       |
| BLEEDING ABNORMALLY, WITH EXTRACTIONS OR SURGERY .... <input type="checkbox"/> | HEPATITIS TYPE ____ ..... <input type="checkbox"/>   | SINUS TROUBLE ..... <input type="checkbox"/>             |
| BLOOD DISEASE ..... <input type="checkbox"/>                                   | HERPES ..... <input type="checkbox"/>                | SKIN RASH ..... <input type="checkbox"/>                 |
| CANCER ..... <input type="checkbox"/>  | HIGH BLOOD PRESSURE ..... <input type="checkbox"/>   | STROKE ..... <input type="checkbox"/>                    |
| CHEMICAL DEPENDENCY ..... <input type="checkbox"/>                             | HIV POSITIVE ..... <input type="checkbox"/>          | SWELLING OF FEET/ ANKLES ..... <input type="checkbox"/>  |
| CHEMOTHERAPY ..... <input type="checkbox"/>                                    | JAUNDICE ..... <input type="checkbox"/>              | SWOLLEN NECK GLANDS ..... <input type="checkbox"/>       |
| CHRONIC FATIGUE SYNDROME ... <input type="checkbox"/>                          | JAW PAIN ..... <input type="checkbox"/>              | THYROID PROBLEMS ..... <input type="checkbox"/>          |
| CIRCULATORY PROBLEMS ..... <input type="checkbox"/>                            | KIDNEY DISEASE ..... <input type="checkbox"/>        | TONSILLITIS ..... <input type="checkbox"/>               |
| CONGENITAL HEART LESIONS ..... <input type="checkbox"/>                        | LATEX SENSITIVITY ..... <input type="checkbox"/>     | TUBERCULOSIS ..... <input type="checkbox"/>              |
| CORTISONE TREATMENTS ..... <input type="checkbox"/>                            | LIVER DISEASE ..... <input type="checkbox"/>         | TUMOR OR GROWTH ON HEAD/ NECK . <input type="checkbox"/> |
| COUGH - PERSISTENT OR BLOODY . <input type="checkbox"/>                        | LOW BLOOD PRESSURE ..... <input type="checkbox"/>    | ULCER ..... <input type="checkbox"/>                     |
| DIABETES ..... <input type="checkbox"/>  | MITRAL VALVE PROLAPSE ..... <input type="checkbox"/> | VENEREAL DISEASE ..... <input type="checkbox"/>          |
|  | NERVOUS PROBLEMS ..... <input type="checkbox"/>      |  |

# ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO \_\_\_\_\_ FOR ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE, AND FOR ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

I AUTHORIZE THE ABOVE DOCTOR AND/ OR ANY PROVIDER OR SUPPLIER OF SERVICES IN THIS OFFICE TO RELEASE THE INFORMATION REQUIRED TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE OF RESPONSIBLE PARTY \_\_\_\_\_ DATE \_\_\_\_\_





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**EFFECTIVE DATE: DECEMBER 12, 2006**  
**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS PRIVACY NOTICE IS PROVIDED TO YOU AS A REQUIREMENT OF A FEDERAL LAW, THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA). THE NOTICE DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE FOR OTHER PURPOSES THAT ARE PERMITTED AND REQUIRED BY LAW. WE UNDERSTAND THIS INFORMATION IS PERSONAL AND WE ARE COMMITTED TO PROTECTING ANY AND ALL INFORMATION ABOUT YOU. THIS NOTICE INCLUDES AND APPLIES TO ALL RECORDS OF YOUR CARE GENERATED BY THIS OFFICE, WHETHER MADE BY YOUR PERSONAL DOCTOR OR OTHER WORKING IN THIS OFFICE. WE WILL ALSO DESCRIBE YOUR RIGHTS TO THE HEALTH INFORMATION WE MAINTAIN ON YOU AND DESCRIBE ANY OBLIGATIONS WE HAVE REGARDING THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION.

**THE LAW REQUIRES THE FOLLOWING:**

- HEALTH INFORMATION THAT IDENTIFIES YOU IS KEPT PRIVATE.
- WE PROVIDE YOU WITH THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES IN REFERENCE TO HEALTH INFORMATION ABOUT YOU.
- WE ABIDE BY THE TERMS OF THE NOTICE THAT IS PRESENTLY BEING ADOPTED.

**I. WAYS WE MAY DISCLOSE HEALTH INFORMATION ABOUT YOU**

- A. TREATMENT:** WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU TO PROVIDE YOU WITH DENTAL CARE, AND MAY DISCLOSE INFORMATION ON YOU TO OTHER DENTISTS, DOCTORS, NURSES, OR OTHER PERSONNEL WHO ARE INVOLVED IN CARING FOR YOU. THESE INDIVIDUALS MAY BE EMPLOYED IN OUR OFFICE, OTHER DENTIST OFFICES, DENTAL LABS, PHARMACIES, OR WITH OTHER HEALTH PROFESSIONAL PROVIDERS TO WHOM WE MAY MAKE REFERRALS.
- B. PAYMENT:** WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU, AS NEEDED, TO OBTAIN PAYMENT FOR SERVICES AT OUR DENTAL OFFICE WHICH INCLUDES BILLING FOR THOSE SERVICES TO YOU, TO INCLUDE INSURANCE COMPANIES OR A THIRD PARTY.
- C. DENTAL SERVICES:** WE MAY DISCLOSE YOUR HEALTH INFORMATION ABOUT YOU FOR OPERATION OF OUR DENTAL PRACTICE WHILE INSURING ALL PATIENTS RECEIVE QUALITY CARE.
- D. APPOINTMENTS:** WE MAY USE AND DISCLOSE HEALTH INFORMATION TO CONTACT YOU IN REFERENCE TO YOUR APPOINTMENTS IN OUR OFFICE. YOU MAY REQUEST WE NOT CONTACT YOU IN REFERENCE TO THESE APPOINTMENTS OR REQUEST THE CALLS BE MADE TO ANOTHER NUMBER OR ADDRESS. YOU WILL ALSO BE NOTIFIED BY POSTCARD TO REMIND YOU OF THESE APPOINTMENTS AND TO REMIND YOU OF ANY REQUIRED MEDICATION THAT NEEDS TO BE TAKEN PRIOR TO THE APPOINTMENT.
- E. JUDICIAL AND ADMINISTRATIVE PROCEEDINGS:** WE MAY DISCLOSE YOUR HEALTH INFORMATION IN THE COURSE OF ANY JUDICIAL OR ADMINISTRATIVE PROCEEDINGS IN RESPONSE TO ANY COURT OR ADMINISTRATIVE ORDER.
- F. LAW ENFORCEMENT:** WE MAY RELEASE YOUR HEALTH INFORMATION IF REQUESTED BY A LAW ENFORCEMENT OFFICER.
- G. CORONERS, FUNERAL DIRECTORS, AND HEALTH EXAMINERS:** WE MAY RELEASE YOUR HEALTH INFORMATION TO A CORONER OR HEALTH EXAMINER IF REQUESTED FOR IDENTIFICATION PURPOSES.

## II. YOUR RIGHTS ABOUT YOUR HEALTH INFORMATION

- A. RIGHT TO INSPECT AND COPY:** YOU HAVE THE RIGHT TO INSPECT AND COPY HEALTH INFORMATION THAT MAY BE USED TO MAKE DECISIONS ABOUT YOUR CARE, INCLUDING HEALTH AND BILLING RECORDS. IN ORDER TO INSPECT AND COPY HEALTH INFORMATION YOU MUST MAKE A REQUEST IN WRITING TO OUR PRIVACY OFFICER.
- B. RIGHT TO AMEND:** IF YOU FEEL THE INFORMATION COLLECTED ABOUT YOU IS INCORRECT YOU MAY THE INFORMATION BE CORRECTED OR AMENDED. YOUR REQUEST MUST BE SUPPORTED BY A REASON FOR THE REQUEST AND SUBMITTED IN WRITING TO THE PRIVACY OFFICER.
- C. RIGHT TO AN ACCOUNTING DISCLOSURE:** YOU HAVE THE RIGHT TO REQUEST AN ACCOUNTING OF CERTAIN DISCLOSURES OF YOUR HEALTH INFORMATION MADE BY OUR OFFICE, WITH EXCEPTION FOR USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND DENTAL SERVICES PREVIOUSLY DESCRIBED.
- D. RIGHT TO REQUEST RESTRICTIONS:** YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT YOUR HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT AND/OR PAYMENT. YOU ALSO HAVE THE RIGHT TO REQUEST LIMITATIONS ON THE HEALTH INFORMATION WE DISCLOSE ABOUT YOU TO SOMEONE WHO IS INVOLVED IN YOUR CARE OR THE PAYMENT FOR YOUR CARE. WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST FOR RESTRICTION IF WE ARE NOT ABLE TO ENSURE COMPLIANCE OR ARE OF THE OPINION IT WILL NEGATIVELY AFFECT YOUR PROVIDED CARE. IF WE AGREE, WE WILL COMPLY WITH YOUR REQUEST UNLESS THE INFORMATION IS NEEDED TO PROVIDE YOU WITH EMERGENCY TREATMENT. YOUR REQUEST MUST BE MADE IN WRITING TO THE PRIVACY OFFICER AND MUST INCLUDE THE INFORMATION YOU ARE REQUESTING TO BE LIMITED AND TO WHOM THE LIMITS MUST APPLY.
- E. RIGHT TO CONFIDENTIAL COMMUNICATIONS:** YOU HAVE THE RIGHT TO REQUEST THAT WE COMMUNICATE WITH YOU REGARDING YOUR DENTAL SERVICES IN CERTAIN WAYS OR LOCATIONS. IN ORDER TO REQUEST CONFIDENTIAL COMMUNICATIONS, YOU MUST MAKE A REQUEST IN WRITING TO OUR PRIVACY OFFICER. WE WILL NOT REQUIRE YOU TO PROVIDE AN EXPLANATION FOR YOUR REQUEST. ALL REASONABLE REQUESTS WILL BE ACCOMMODATED AND YOUR REQUEST MUST SPECIFY HOW AND WHERE YOU WISH TO BE CONTACTED.
- F. RIGHT TO A PAPER COPY OF THIS NOTICE:** YOU HAVE THE RIGHT TO A PAPER COPY OF THIS NOTICE BY CONTACTING OUR PRIVACY OFFICER.
- G. CHANGES TO THE NOTICE:** WE RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE OF OUR PRIVACY PRACTICES AT ANY TIME. WE WILL IMMEDIATELY NOTIFY ALL PATIENTS BY POSTING A WRITTEN NOTICE IN OUR OFFICE. WE RESERVE THE RIGHT TO REVISE OR CHANGE THE NOTICE EFFECTIVE FOR HEALTH INFORMATION ALREADY ON FILE ABOUT YOU IN ADDITION TO ANY INFORMATION WE RECEIVE IN THE FUTURE.
- H. ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE:** DR. JOHNATHAN P. EARP CONTINUES TO OFFER OUR PATIENTS QUALITY CARE AND WILL ASSURE OUR PATIENTS HEALTH INFORMATION WILL BE PROTECTED PER THE GUIDELINES OF THIS OFFICE. WE ARE REQUESTING THAT EACH PATIENT SIGN A SEPARATE FORM ACKNOWLEDGING YOU HAVE RECEIVED A COPY OF THIS NOTICE THAT WILL BE FILED IN YOUR DENTAL CHART.

## III. COMPLAINTS

YOU HAVE THE RIGHT TO REGISTER COMPLAINTS TO JOHNATHAN P. EARP, DDS AND TO THE US SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IF YOU BELIEVE YOUR RIGHTS HAVE BEEN VIOLATED. YOU MAY REGISTER A COMPLAINT TO JOHNATHAN P. EARP, DDS BY CONTACTING THE PRIVACY OFFICER AT 2446 EMERALD PLACE, GREENVILLE, NORTH CAROLINA, 27834. WE ENCOURAGE YOU TO EXPRESS ANY CONCERNS YOU MAY HAVE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION.



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## NOTICE OF PRIVACY ACT ACKNOWLEDGMENT FORM

THIS FORM ACKNOWLEDGES RECEIPT OF OUR NOTICE OF PRIVACY POLICY PRACTICES AND TO DOCUMENT OUR EFFORTS TO OBTAIN THAT ACKNOWLEDGEMENT.

IN SIGNING THIS AGREEMENT I UNDERSTAND AND AGREE WITH THE PRIVACY PRACTICES OF THIS OFFICE.

---

NAME OF PATIENT (PLEASE PRINT)

---

SIGNATURE OF PATIENT OR GUARDIAN  
(IF PATIENT IS UNDER THE AGE OF 18, A PARENT OR GUARDIAN MUST SIGN.)

DATE

### FOR OFFICE USE ONLY

---

PLEASE SPECIFY THE EXACT REASON WHY THIS PATIENT CHOSE NOT TO SIGN THE ACKNOWLEDGMENT OF THE RECEIPT OF THE NOTICE OF PRIVACY.

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SIGNATURE OF STAFF MEMBER

TITLE

DATE