EARP DENTISTRY
FAMILY, COSMETIC & IMPLANT DENTISTRY

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, NC 27834

3380 East Wilson Street, Farmville, NC 27828

363 US Highway 64, Plymouth, NC 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:_____

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:_____

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:_____

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:_____

City, State:_____ Date of Last Dental Visit:_____

Date of Last X-Rays_____How Often Do You Floss?_____

How Often Do You Brush?_____

Please check all that apply:

Bad Breath..... ☐ Sensitivity to Cold..... ☐

Bleeding Gums..... ☐ Sensitivity to Heat..... ☐

Blisters on Lips or Mouth..... ☐ Sensitivity to Sweets..... ☐

Fingernail Biting..... ☐ Sensitivity when Biting..... ☐

Grinding Teeth..... ☐ Frequent Headaches..... ☐

Lip or Cheek Biting..... ☐ Jaw, Head or Neck Injuries..... ☐

Loose Teeth or Broken Fillings... ☐ Jaw Difficulty:

Orthodontic Treatment..... ☐ Clicking and/ or Pain..... ☐

Pain Around Ear..... ☐ Tooth Pain..... ☐

Periodontal Treatment..... ☐

Medical History

Physician's Name: _____Date of Last Visit:_____

1. Are you currently under medical treatment? ..... Y N
2. Have you ever had any serious illnesses or operations? ..... Y N
3. Are you currently taking any medication? ..... Y N

   Please Describe: _____

   _____
4. Do you smoke? ..... Y N
5. Do you use alcohol, cocaine or other drugs? Y N
6. Do you wear contact lenses? ..... Y N

7. Have you had any allergic Reactions to the following:

Local Anesthetics (eg. novocaine) ..... Y N
Penicillin or other Antibiotics ..... Y N
Sulfa Drugs ..... Y N
Barbiturates (eg. sleeping pills) ..... Y N
Sedatives ..... Y N
Iodine ..... Y N
Aspirin ..... Y N
Other ..... Y N

8. (Woman Only) Are You:

Pregnant? ..... Y N
Nursing? ..... Y N
Taking birth control pills? ..... Y N

Check all that apply:

AIDS ..... ☐
Anemia ..... ☐
Arthritis, Rheumatism ..... ☐
Artificial Heart Valves ..... ☐
Artificial Joints .... ☐
Asthma ..... ☐
Back Problems ..... ☐
Bleeding abnormally, with extractions or surgery ..... ☐
Blood Disease ..... ☐
Cancer ..... ☐
Chemical Dependency ..... ☐
Chemotherapy ..... ☐
Chronic Fatigue Syndrome ..... ☐
Circulatory Problems ..... ☐
Congenital Heart Lesions ..... ☐
Cortisone Treatments ..... ☐
Cough - persistent or bloody ..... ☐
Diabetes ..... ☐
Emphysema ..... ☐
Epilepsy ..... ☐
Fainting or Dizziness ..... ☐
Glaucoma ..... ☐
Headaches ..... ☐
Heart Murmur ..... ☐
Heart Problems .... ☐
Hepatitis Type ___.. ☐
Herpes ..... ☐
High Blood Pressure ..... ☐
HIV Positive ..... ☐
Jaundice ..... ☐
Jaw Pain ..... ☐
Kidney Disease ..... ☐
Latex Sensitivity .. ☐
Liver Disease ..... ☐
Low Blood Pressure ..... ☐
Mitral Valve Prolapse ..... ☐
Nervous Problems. ☐
Pacemaker ..... ☐
Psychiatric Care .. ☐
Radiation Treatment ..... ☐
Respiratory Disease ..... ☐
Rheumatic Fever ... ☐
Scarlet Fever ..... ☐
Shortness of Breath ..... ☐
Sinus Trouble ..... ☐
Skin Rash ..... ☐
Stroke ..... ☐
Swelling of Feet/ Ankles ..... ☐
Swollen Neck ..... ☐
Glands ..... ☐
Thyroid Problems.. ☐
Tonsillitis ..... ☐
Tuberculosis ..... ☐
Tumor or growth on head/ neck ..... ☐
Ulcer ..... ☐
Venereal Disease .. ☐

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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Medical History Update

Patient Name:_____ Account #:_____

Medical Doctor:_____ Phone (optional):_____

Specialist(s):_____ Phone (optional): _____

Allergies:_____

Please list all surgeries (past five years)

Type of Procedure and Reason for Surgery	Doctor	Date

Medications

Please note that it is very important that you list all of your medications for us.

Office Notes:

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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 wiring 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 Date

(If patient is under the age of 18, a parent or guardian must sign.)

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.

_____

Signature of staff member Title Date