2446 Emerald Place
Greenville, North Carolina 27834

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

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 # ____________________________

EARP DENTISTRY

FAMILY, COSMETIC & IMPLANT DENTISTRY

Primary Care Doctor: ______________________________ Date of Last visit: ________________________

Specialist(s): ____

Date of Last Visit: ____

Please list major surgeries/Hospitalizations (within the past five years)

Type of Procedure and Reason for Surgery	Doctor	Date

Are you currently under medical treatment? Y N

Are you allergic to any of the following medications:
__Penicillin __Sulfa Drugs __Codeine __Aspirin
__Other (Please List):________________________________

Are you allergic to any foods/materials? Y N
Please List: ____________________________________

Have you ever had an adverse reaction to local anesthetic? Y N

Have you ever taken Fosomax, Boniva, Actonel or any other medications containing bisphosphonates? Y N

Check any that apply: __Smoker (__ packs/day)
__Smokeless tobacco __Vape___Ex-smoker

Do you drink alcohol? Y N
If yes, ___drinks/week

Do you use other substances or recreational drugs? Y N

WOMEN

are you pregnant? Y N
If yes, Due date:______________
are you trying to get pregnant? Y N
Nursing? Y N
Taking birth control pills? Y N

Medication

Please note that it is very impor:ant that you list all of your medications for us.

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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 (HIPAA). 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.

2446 Emerald Place
Greenville, North Carolina 27834

MEDICAL RECORDS TRANSFER

Date:________________________

Patient Name:_________________________ DOB:__________ Phone Number:___________________

Records Sent to:	Records Sent from:
Earp Dentistry	____________________________________
2446 Emerald Place	____________________________________
Greenville, NC 27834	____________________________________

Medical History

_______________ Last Recall Appointment	Pre-medications Needed:__________________
_______________ Last Office Visit	Allergies:______________________________
_______________ Last Bitewing Series	Other:_________________________________
_______________ Last Panorex	______________________________________

I _______________________ hereby authorize the release of my medical records to
(Print patient name here)
the above stated office.

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Signature of Patient or Legal Guardian Date