Patient Registration Date: _____

First Name:_____ Last Name:_____ Middle Initial:_____
Preferred Name: _____ Occupation:_____
Address:_____ City:_____ State: _____ Zip:_____
Home Phone:_____ Work Phone: _____Cell Phone:_____
Birth Date:_____ Social Security #:_____ Driver's License #_____
Sex: o M o F Marital Status: o Married o Single o Divorced o Separated o Widowed

If the patient is under the age of 18, who is the Parent(s) and/or Legal Guardian(s)?

First Name:_____ Last Name:_____ Middle Initial:_____
Preferred Name: _____
Address:_____ City:_____ State: _____ Zip:_____
Home Phone:_____ Work Phone: _____Cell Phone:_____
Birth Date:_____ Social Security #:_____ Driver's License #_____
Sex: o M o F Marital Status: o Married o Single o Divorced o Separated o Widowed

Emergency Contact Name and Number_____

How did you hear about us? o Insurance Website o Money Mailer o Neighborhood Source o Internet o HomePages
o Yellow Pages o eDentist.com o Other:_____ o Friend or Relative_____

Primary Insurance Information

Name of Insured:_____ _____Relationship to Insured: o Self o Spouse o Child o Other

Insured Soc. Sec. _____	Insured DOB: _____
Employer:_____	Insurance Company: _____
Address:_____	Address:_____
Address 2:_____	Address 2:_____
City, State, Zip:_____	City, State, Zip:_____

Employment Status: o Full Time o Part Time o Retired

**If you have Secondary Insurance, please inform the receptionist.

Financial Policy:

- PAYMENT IS DUE AT THE TIME OF SERVICE. The full balance of treatment is due at the time service is rendered. Payment plans are available through Care Credit and we also accept cash, check, Visa, MasterCard, Discover, and American Express.
- Assignment of Dental Insurance Benefits – Our office files insurance benefits as a courtesy to you. Claims unpaid by your insurance company after 60 days are your responsibility and will be due in full. All deductibles, copayments, and non-covered fees are due at the time of service. A CURRENT copy of your insurance card must be kept on file to utilize this service. Our office reserves the right to discontinue and/or refuse to file claims.
- Service Charges – A $25 fee will apply to all returned checks. A fee of $50 will be charged for appointments cancelled with less than 24 hour notice. Our office reserves the right to pursue any other remedy by law.
- Delinquent Accounts – Account balances exceeding 90 days may be pursued through third party collection agencies at the account holder's responsibility at a charge of 8% interest.

Authorizations

I affirm that the information given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform to office in any changes of address, employment information, insurance information, and medical status. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly to Eriks Dental all insurance payments otherwise payable to me. I understand that I am responsible for the full balance, including but not limited to third party collection fees, court fees, filing fees, and attorney fees.

I authorize the dental staff to perform all necessary dental treatment needed. Like any treatment of the body, there are certain risks, benefits, limitations, and alternatives to treatment and no guarantee of the outcomes or cures will be given. I understand it is difficult to predict any symptoms, if any, I may encounter as a result of treatment.

I affirm that my signature represents my agreement to all the above mentioned terms.

Signature of Patient, Parent, or Guardian: _____

Medical and Dental History

Patient Name_____ Date of Birth_____

Please fill out the form completely to the best of your ability. Health problems that you may have, or medication(s) that you may be taking may have an important interrelationship with the dental care you receive. Thank you.

Name of **Primary care physician** _____ Phone: (____)_____-_____
(First and last name, please)
Address/Location of Primary care Physician:_____
List any prior **Hospitalizations or surgeries** including the year and reason for hospitalization or surgery:
_____
_____
Have you ever had a serious head or neck injury? If yes, explain:_____
Please list any **medication(s)** you are currently taking, including dosage and frequency:
_____
_____
Do you take, or have you taken Phen-Fen, Redux, Bonivia, Fosamax, Actonel, Didronel, Shelid, Aredia, Zometa? (please circle)
Are you on a **special diet**? If yes, explain:_____
Do you use **tobacco**? If yes, how much and how often?_____ Smoke or smokeless (please circle)
Do you use **controlled substances**? If yes, please name and include the dosage and frequency:_____
Have you ever had **prolonged or unusual bleeding**? If yes, explain:_____

Women Only: Are you □ Pregnant/Trying to get pregnant? □ Nursing? □ Taking Oral Contraceptives?

Are you **allergic** to any of the following? □ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics
□ Other: _____ Please explain the reaction _____

Do you have, or have you had, any of the following?

□ AIDS/HIV positive	□ Chest Pains	□ Frequent Headaches	□ Irregular Heartbeat	□ Scarlet Fever
□ Alzheimer's disease	□ Cold Sores/Fever Blisters	□ Genital Herpes	□ Kidney Problems	□ Shingles
□ Anaphylaxis	□ Congenital Heart Disorder	□ Glaucoma	□ Leukemia	□ Sickle Cell Disease
□ Anemia	□ Convulsions	□ Hay Fever	□ Liver Disease	□ Sinus Trouble
□ Angina	□ Cortisone Medicine	□ Heart Attack/Failure	□ Low Blood Pressure	□ Spina Bifida
□ Arthritis/Gout	□ Diabetes	□ Heart Murmur	□ Lung Disease	□ Stomach/Intestinal
□ Artificial Heart Valve	□ Drug Addiction	□ Heart Pace Maker	□ Mitral Valve Prolapse	□ Stroke
□ Artificial Joint	□ Easily Winded	□ Heart Trouble/Disease	□ Pain in Jaw Joints	□ Swelling of Limbs
□ Asthma	□ Emphysema	□ Hemophilia	□ Parathyroid Disease	□ Thyroid Disease
□ Blood Disease	□ Epilepsy or Seizures	□ Hepatitis A	□ Psychiatric Care	□ Tonsillitis
□ Blood Transfusion	□ Excessive Bleeding	□ Hepatitis B or C	□ Radiation Treatments	□ Tuberculosis
□ Breathing Problem	□ Excessive Thirst	□ Herpes	□ Recent Weight Loss	□ Tumors or Growth
□ Bruise Easily	□ Fainting Spells/Dizziness	□ High Blood Pressure	□ Renal Dialysis	□ Ulcers
□ Cancer	□ Frequent Cough	□ Hives or Rash	□ Rheumatic Fever	□ Venereal Disease
□ Chemotherapy	□ Frequent Diarrhea	□ Hypoglycemia	□ Rheumatism	□ Yellow Jaundice

Have you ever had a **serious illness** not listed above? If yes, please explain: _____
Have you ever had a **reaction to local anesthetic**? If yes, please explain: _____
Have you ever had **complications or illness following dental treatment**? If yes, please explain: _____
Are you **currently in any pain**? If yes, please explain: _____
When was your last dental checkup? _____ Last dental cleaning? _____ X-Rays? _____
What is the name of your previous Dentist? _____Address/Location: _____
Have you ever been treated for **Active Periodontal Disease**? If yes, how long ago? _____
How often do you brush? _____ How often do you floss? _____
If you could change anything at all about your smile, what would it be? _____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. If I ever have any change in my health condition or the medications I take, I will inform the Doctor on my next appointment.

Signature of Patient, Parent, or Guardian: _____ *Date:* _____

Walnut Street Family Dentistry
601 E Walnut St, Frankfort, IN 46041 765-659-4977

**Please sign the areas highlighted in GRAY. **

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect August 1, 2013 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. You may request that our office does not disclose treatment information to a health plan in the event of out of pocket expenses paid in full.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by you authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of you incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to make reasonable inferences of you best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing and Fundraising Health-Related Services: We will not use your health information for marketing or fundraising communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as telephone calls, voicemail messages, email, paging, postcards and/or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $15.00 for the first 10 pages of patient records and $.25 for additional pages; if radiographs are copied a reasonable fee will be accessed for record duplication and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure.

Disclosing Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12 month period, we charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (you must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
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.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. While it is a violation of HIPAA Security to send your private health information over normal email without encryption or security measures, you may request your information via regular email only if you assume the possible security risks of emailing sensitive information.

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 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 information 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.
Contact:

Douglas A. Eriks, DDS
601 E. Walnut St.
Frankfort, IN 46041
765-659-4977

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.
****You May Refuse to Sign This Acknowledgement****
I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Signature)
_____
(Date)

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.
I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
(Please Print Name) Relationship
_____ _____
(Please Print Name) Relationship
_____ _____
(Please Print Name) Relationship

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)

_____
_____
_____