GENERAL INFORMATION

Patient's Last Name_____First_____Middle_____S.S.#_____

Address:_____City:_____State:_____Zip Code:_____

Home Phone:_____Male [ ] Female [ ] Date of Birth:_____ Single [ ] Married [ ]

Cell Phone:_____ Work Phone:_____ Parent [ ] Guardian [ ]

EMPLOYER:_____Employer's Phone:_____

Address:_____City:_____State:_____Zip Code:_____

If married, spouse's name: _____S.S.#_____

Spouse's Employer:_____Phone:_____

Whom may we thank for referring you to our office:_____

Responsible Party – Check here if same as patient [ ]

Bill Account To:_____Relationship:_____

Address:_____City:_____State:_____Zip Code:_____

Phone:_____Responsible Party's S.S.#_____

If the patient is a child, name of school:_____City:_____

Father's Name:_____S.S.#_____

Father's Employer:_____Phone:_____

Mother's Name:_____S.S.#_____

Mother's Employer:_____Phone:_____

DENTAL INSURANCE INFORMATION:

Primary Dental Insurance:_____Deductible$_____

Policy#_____Address:_____

Group#_____Effective Date:_____

Subscriber's Name:_____D.O.B:_____Insurance Phone:_____

Secondary Dental Insurance:_____Deductible$_____

Policy#_____Address:_____

Group#_____Effective Date:_____

Subscriber's Name:_____D.O.B:_____Insurance Phone:_____

OFFICE POLICY

I understand that I am fully responsible for payment of any fees incurred at this office. I agree to pay for services on the day they are performed unless I make other arrangements with the business manager. These include: 5% cash discount for accounts over $1000.00 pain in full on the day treatment begins – or ½ balance at beginning of treatment and remaining half due upon completion of treatment. Visa, Mastercard, and Care Credit Card (available through application) are accepted. Any balance that is overdue by 90 days will be turned over to a collection agency.

Signed: _____Date: _____

I hereby authorize any needed treatment and the release of any information regarding this treatment for the purpose of obtaining insurance benefits.

Signed: _____Date: _____

I hereby authorize payment directly to Dr. Ethan Erwin and Dr. Robert J. Barnett of the insurance benefits otherwise payable to me.

DR. ETHAN ERWIN, DDS & DR. ROBERT J. BARNETT, DDS
102 RIDGEWAY ST, HOT SPRINGS, AR 71901 | OFFICE 501.624.7129 | FAX 501.624.2471
SMILEHOTSPRINGS@GMAIL.COM

MEDICAL HISTORY

Your Chief Oral Complaint:_____

Are you currently under the care of a physician? Yes____ No____

Are you taking any medications, pills, or drugs? Yes____ No____

Describe any current medical treatment including drugs taken:_____

Physician's Name: _____ Physician's Telephone:_____

Physician's Address:_____

Have you ever been hospitalized or had a major operation? Yes____ No____

Have you ever had a serious head or neck injury? Yes____ No_____

Do you take, or have you taken, Phen-Fen or Redux? Yes____ No____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes____ No____

Do you use tobacco or controlled substances? Yes____ No____

Women: Are you...

Pregnant: Yes____ No____ Nursing: Yes____ No____ Taking oral contraceptives: Yes____ No____

Are you allergic to any of the following?

___Aspirin ___Acrylic ___Codeine ___Erythromycin ___Latex ___Metal ___Nitrous Oxide

___Penicillin ___Sulfa Drugs ___Local Anesthetics ___Other: _____

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

___Acid Reflux/G.E.R.D
___AIDS/HIV Positive
___Alzheimer's Disease
___Anaphylaxis
___Angina Pectoris
___Arthritis/Gout
___Artificial Heart Valve
___Artificial Joints (Hip, Knee, ect)
___Asthma
___Blood Disease
___Blood Transfusion
___Breathing Problems
___Bruise Easily
___Cancer
___Chemotherapy
___Cold Sores/Fever Blisters
___Chronic Bronchitis/Emphysema
___Congenital Heart Disorder
___Congenital Heart Lesions
___Coronary Stents
___Diabetes
___Drug or Alcohol Abuse
___Epilepsy or Seizures/Convulsions
___Excessive Bleeding
___Fainting or Dizzy Spells
___Heart Attack/Failure
___Heart Murmur
___Heart Pacemaker
___Heart Surgery
___Heart Trouble/Disease
___Hemophilia
___Hepatitis A
___Hepatitis B or C
___High Blood Pressure
___High Cholesterol
___Hypoglycemia
___Kidney Trouble
___Leukemia
___Liver Disease
___Mitral Valve Prolapse
___Nervousness
___Osteoporosis
___Pain in Jaw Joints
___Psychiatric Treatment
___Radiation Treatment
___Recent Weight Loss
___Renal Dialysis
___Sickle Cell Disease
___Sinus Trouble
___Spina Bifida
___Stroke
___Thyroid Disease
___Tuberculosis

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Dental History

Please check any of the following problems that apply to you.

___ Sensitivity (hot, cold, sweet

___ Tooth pain/discomfort when chewing

___ Jaw joint pain

___ Headaches, earaches, neck pain

___ Teeth or fillings breaking

___ Grinding or clenching teeth

___ Bleeding/swollen or irritated gums

___ Loose, tipped or shifting teeth

___ Bad breath or bad taste in your mouth

If you could change your smile:

___ Whiten them

___ Close spaces

___ Straighten them

___ Repair chipped teeth

___ Replace missing teeth

___ Replace black metal fillings with tooth-colored fillings

___ Replace old crowns that don't match

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

___ Dentures ___ Partial Dentures

___ Braces ___ Bite splint/night guard

___ Periodontal (gum) treatments

If you could whiten your teeth for a cost anyone could afford, would you do it?

___ Yes ___ No

Do you smoke or use chewing tobacco?

How much? _____

For how long? _____

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where you would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Name of Previous Dentist **City/State** **Phone**

_____

Why did you leave your previous dentist?

_____

What is the most important thing to you about your future smile and dental health?

_____

What is the most important thing to you about your dental visit today?

_____

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Medical Information Release Form

(HIPPA Release Form)

Name: _____Date of Birth: ____/____/____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____

☐ Information is not be released to anyone

*This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call:

- ☐ my home_____
- ☐ my work _____
- ☐ my cell _____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ **Date:** ____/____/____

Witness: _____ **Date:** ____/____/____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Print name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement to receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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SMILE
HOT SPRINGS

ETHAN ERWIN, DDS & ROBERT J. BARNETT, DDS

NOTICE OF PRIVACY PRACTICES

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.

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 April 14,2003, 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.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on this website.

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.

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 your 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 your 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 the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing 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, 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 voicemail messages, postcards, 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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure 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, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may 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 website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, 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 on this website. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address 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. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.