Patient Information

Date _____

Patient Name _____
Last First Middle

Address _____
Street City State Zip

Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Alternate Phone _____

Previous address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouses' Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Alternate Phone _____

Dental Insurance Information

Policy Holder _____ Insured's ID# _____

Insurance Company _____ Group No. _____ Phone # _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Policy Holder _____ Insured's ID# _____

Insurance Company _____ Group No. _____ Phone # _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative **NOT** living with you _____

Complete Address _____

Phone _____

While we will assist you in filing any insurance claims, the entire amount of our fees are the patient's responsibility. Any amount failed to pay or contested or denied by the insurance is between the patient and the insurance company. Our service was to the patient and the patient is responsible for the full amount.

Any patient account unpaid after 60 days from the date of service may be charged interest at the rate of 2% per month. In case of failure to pay, we reserve the right to add additional costs like, but not limited to, reasonable collection fees, finance charges, late charges, filing fees, court costs and attorney's fees. These costs are also the patient's responsibility. I understand that credit bureau reports may be obtained.

Signature (Parent's signature if patient is a minor) _____

I authorize payment of the dental benefits directly to Lima Road Dentistry, PC. _____

Today's Date: _____ Age: _____

Patient's Name: _____ Date of Birth: _____

Your answers are for our records only and will be considered confidential.

Please circle yes or no

1. Are you in good health? ..... yes no
2. Has there been any change in your health in the past year? ..... yes no
3. Are you now under the care of a physician? ..... yes no
   if yes, for what condition(s): _____
4. The name and address of my physician is: _____
   _____
5. Have you had any serious illnesses or operations in the past 5 years? ..... yes no
   if yes, what? _____
6. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever ..... yes no
   b. High blood pressure ..... yes no
   c. Heart condition or problem ..... yes no
   d. Stroke ..... yes no
   e. Heart attack ..... yes no
   f. Diabetes ..... yes no
   g. Asthma or hay fever ..... yes no
   h. Sinus trouble ..... yes no
   i. Hives or skin rash ..... yes no
   j. Frequently thirsty ..... yes no
   k. Fainting or seizures ..... yes no
   l. Hepatitis ..... yes no
   m. Arthritis ..... yes no
   n. Tuberculosis ..... yes no
   o. Ulcers/colitis ..... yes no
   p. Venereal disease ..... yes no
   q. Kidney trouble ..... yes no
   r. Persistent cough or coughing up blood ..... yes no
   s. Bruise easily _____ yes no
   Explain above conditions: _____
   _____
7. Have you had abnormal bleeding associated with surgery, injury or tooth extraction? ..... yes no
8. Have you ever required a blood transfusion? ..... yes no
9. Do you have any artificial body parts (heart valve, hip joint, etc.)? ..... yes no
10. Are you taking any medication: ..... yes no
    If yes, what? _____
11. Do you have AIDs or HIV? ..... yes no
12. Have you had any chemotherapy or radiation treatments? ..... yes no
13. Have you ever experienced an unusual reaction to any of the following drugs?
    a. Local anesthetics ..... yes no
    b. Penicillin ..... yes no
    c. Aspirin ..... yes no
    Other _____
    d. Codeine ..... yes no
    e. Sulfa drugs ..... yes no
    f. Barbiturates (sleeping pills) ..... yes no
    g. Iodine ..... yes no
14. Do your gums bleed when you brush your teeth? ..... yes no
15. WOMEN: Are you pregnant? ..... yes no
16. Do you have clicking or pain in your jaw joint (TMJ)? ..... yes no
17. Have you been told that you have a snoring problem? ..... yes no
18. Are you taking antibiotics? ..... yes no
19. Do you want to keep your teeth? ..... yes no
20. Do you have soreness or swelling under your jaws, arms or any other part of your body? ..... yes no
21. Do you have prolonged periods of “feeling sick”? ..... yes no
22. Do you have a cardiac pacemaker? ..... yes no
23. Do you use tobacco products? ..... yes no
24. If yes, are you interested in becoming smoke-free? ..... yes no
25. Do you have any disease, condition or problem not listed above that you think we should know about? ..... yes no
    If yes, explain: _____
26. When was the last time your teeth were cleaned professionally by a dental hygienist? _____
27. Please rate your dental anxiety level on a scale of 1 to 10, with 10 being “extremely anxious” about 1 being “not anxious at all” _____
28. How did you hear about our office? ☐ Friend or relative (who:) _____
    ☐ Saw sign while passing ☐ Phone book ☐ Neighborhood association ☐ Mailing

To the best of my knowledge the above information is true and correct.

_____
Signature

LIMA ROAD DENTISTRY

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 (MM/DD/YR), 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.

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, 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 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. 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 $0.___ for each page, $___ per hour for staff time to locate and copy your health information, 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 at the end of this Notice for a full explanation of our fee structure.)

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, for the last 6 years, 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 Web site 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.

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 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.

Contact officer: Amy McCracken

Telephone: (260)489-4090 Fax: (260)490-0033

Address: 9019 Lima Road

Fort Wayne, IN 46818-1801

Lima Road Dentistry, P.C.
Privacy Practices Acknowledgement

Date:_____

Name:_____

Patient's Date of Birth:_____

Patient's Phone Number:_____

I here by authorize the staff of Lima Road Dentistry to discuss any necessary medical, dental and billing information on my behalf with:

Name	D.O.B.	Relationship	Phone #

The above person/persons will have authority to call on my behalf until I revoke this in writing.

Signature:_____

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There will be no one calling on my behalf regarding my medical or billing information. Do not share information regarding me with anyone other than authorized medical personnel.

Signature:_____

Updates:_____ _____ _____
Initial/Date Initial/Date Initial/Date
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