East Center Dental
Family, Cosmetic & Implant Dentistry

Patient Registration

Dr. Karen L. Scripture ● Dr. Michael L. Rudolph

Name: Last:_____ First:_____ Middle Initial:_____ □ Male □ Female

I prefer to be called:_____ If Child, Parents Name: Dad:_____ Mom:_____

Date of Birth:_____/_____/_____ Your Social Security Number:_____-____-_____

Address_____ City_____ State_____ Zip_____

Phone: Home_____ Work_____ Cell_____

E-mail _____ □ **Would you like to receive appointment reminders electronically?**

□ Single □ Married □ Separated □ Divorced □ Widowed □ Minor

Your Employer_____ Position_____ How Long Held_____

Who is responsible for account?_____ DOB:____/____/____ Payment method: □ Ins. □ Cash □ Credit

Other Family Members in this Practice_____

Whom may we thank for this referral?_____

Emergency contact (not in living w/you) Name_____ Phone_____

Dental Insurance

Subscriber Name _____

Date of Birth:_____/_____/_____

Subscribers SSN_____-_____-_____

Subscriber's Employer_____

# of Years Employed?_____

Name of Ins. Company_____

_____

Address_____

City_____ State_____ Zip_____

Telephone#_____

Program or Policy# _____

Union Local or Group#_____

_____

Family members covered by this plan:_____

_____

Release

I authorize Dr. Scripture or Dr. Rudolph to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits and to another dentist.

I hereby authorize payment of insurance benefits to Dr. Scripture or Dr. Rudolph, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full for all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental payer.

I attest to the accuracy of the information on this page.

Patient (or Guardian) Signature:

_____

Today's Date:_____

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Adult Patient History

Today's Date:____/____/____ Date of Birth:____/____/____

Name:_____ I prefer to be called:_____

Phone Number:_____ Spouse Name:_____

MEDICAL HISTORY

Name of Physician:_____ Physicians Phone #:_____ Last Visit:_____

Current Health: Excellent Good Fair Poor

In the last 21 days, have you been out of the country? YES NO Do you have a fever? YES NO

Please "X" each box if the answer is "yes". Leave blank if "no".

☐ Do you smoke or use tobacco? How much per day?_____

Please list prescription medication you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

☐ Have you had any artificial joints or valves placed? Do you need to pre-medicate before dental treatment? Please explain_____

☐ Women: Are you or could you be pregnant? What is your due date?_____

☐ Have you had any serious medical problems in the past 5 years? Please explain:_____

_____

Have you ever had or been treated for any of the following diseases or medical problems?

☐ Yes (check all that apply) **☐ No**

☐ Heart Attack/Stroke	☐ Anemia	☐ Chronic Sinus
☐ Cancer/Chemotherapy	☐ Heart Murmur	☐ Malignancies
☐ Drug/Alcohol Addiction	☐ Rheumatic Fever	☐ Mastoid/Ear Infection
☐ AIDS/HIV	☐ Epilepsy/Seizures/Fainting	☐ Stomach Trouble
☐ Diabetes	☐ High Blood Pressure	☐ Lung Problems
☐ Hepatitis/Jaundice	☐ Low Blood Pressure	☐ Fainting Spells
☐ Abnormal Bleeding	☐ Psychiatric Problems	☐ Blood Disorders
☐ Kidney Problems	☐ Asthma	☐ Glaucoma
☐ Tuberculosis	☐ Allergies	☐ Venereal Disease/Herpes

☐ Have you been treated for any other illness not listed above? Please explain:_____

Are you allergic to any of the following?

☐ Yes (check all that apply) **☐ No**

☐ Penicillin	☐ Sulfa	☐ Codeine
☐ Dental anesthetic	☐ Erythromycin	☐ Other: _____
☐ Aspirin	☐ Latex	☐ Other: _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

DENTAL HISTORY

On your previous dental visits:

- □ Were you given local anesthetic?
- □ Were x-rays taken?
- □ Were home instructions given?
- □ Were regular preventative visits made?
- □ Was there a history of dental decay?
- □ Were there any special problems?

Is there sensitivity in your mouth to:

- □ Heat
- □ Sweets
- □ Chewing
- □ Cold
- □ Biting
- □ Previous injury

Do you have a history of:

- □ Nail biting
- □ Hard swallowing
- □ Mouth breathing
- □ Biting hard objects
- □ Frequent headaches
- □ Neck & shoulder pain
- □ Jaws pop or click
- □ Excessive bleeding
- □ Bleeding gums
- □ Food collection between teeth
- □ Fluoride treatments
- □ Tooth sensitivity tests

Why have you come to the dentist today?

_____

Why did you leave your last dentist?

_____

What did you like most about any dentist you have ever seen?_____

How would you describe the condition of your teeth or gums? Good Fair Poor

□ Are you currently in pain or discomfort with your teeth or gums? Please explain:_____

_____

The date of your last dental visit:____/____/____

Previous Dentist Name:_____

How often do you brush your teeth?_____

Floss your teeth?_____

□ Do your gums bleed when you brush?
□ When you Floss?

If you could change anything about your smile, what would you like to change?_____

□ Have you experienced pain in your jaw joint? □ Do you grind your teeth?

□ Have you been treated for TMJ symptoms? Please explain:_____

Doctor's Comments:_____

_____

Release:

I state that this information is correct to the best of my knowledge.

I authorize Dr. Scripture or Dr. Rudolph to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my health care, advice and treatment provided to me, for the purpose of evaluating and administering claims for insurance benefits or specialist referral.

I authorize payment of insurance benefits to Dr. Scripture or Dr. Rudolph, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full for all accounts. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part by my dental payer.

Patients Signature:_____ Date:____/____/____

Doctors Signature:_____ Date:____/____/____

East Center Dental
Family, Cosmetic & Implant Dentistry

2104 E CENTER ST, | WARSAW IN, 46580 | 5742691787

Written Financial Policy

Thank you for choosing East Center Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

We offer a 5% courtesy discount to patients who pay for their treatment with cash or check.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

- East Center Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.
- We accept payment in thirds for treatments over $900.00. For plans requiring multiple appointments, alternative payment arrangements may be provided.
- For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.
- A fee of $50 is charged for patients who miss or cancel more than 1 time in a 12 month period without 24-hour notice.
- East Center Dental charges $30.00 for returned checks.
- Patients will be responsible for costs incurred to collect any unpaid debt including but not limited to collection fees, interest fees and attorney fees.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

EAST WARSAW DENTAL GROUP, LLC

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **05/07/2014** 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 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.

Our Privacy Official: KARLEI HILL

Telephone: 574-269-1787

Fax: 574-267-1610

Address: 2104 E. Center St., Warsaw, IN 46580

E-mail: karleih@warsawsmiles.com

East Center Dental
Family, Cosmetic & Implant Dentistry

Karen L. Scripture ● Michael L. Rudolph
2104 E. Center St., Warsaw, IN 46580
Phone: 574-269-1787 ● Fax: 574-267-1610

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have read a copy of this Office's Notice of Privacy Practices.

PLEASE PRINT NAME_____

Do you have anyone that you would allow our office to release dental information to? Yes____No____

Please List:

Name:_____Date of Birth:_____

Name:_____Date of Birth:_____

If your child (under age 18) is brought to our office for his/her dental appointment by someone other than yourself, may we release dental/medical information to him/her? Yes_____No _____

SIGNATURE:_____DATE_____

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

___Communication barriers prohibited obtaining the acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___Other (please specify)_____