363 US HWY 64
Plymouth, NC 27962
Phone 252.793.5942
Fax 252.793.5426

# Pruitt & Earp Dentistry

Family, Cosmetic & Implant Dentistry

2446 Emerald Place
Greenville, NC 27834
Phone 252.756.3313
Fax 252.756.0146

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Middle Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Email _____

Sex: __M __ F Martial Status: __ Minor __ Single __ Married __ Divorced __ Widowed

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 # _____

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 Fosamax, 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

## Medications

**Please note that it is very important that you list all of your medications for us.**

# Dental History

**Former Dentist**_____

**City, State**_____

**Date of Last Dental cleaning**_____

**Date of Last X-Rays**_____

**How Often Do You Floss?**_____

**How Often Do You Brush?**_____

# Medical History

**Please circle Yes (y) or No (n) if you <u>have or have had</u> any of the following:**

Y N Congenital Heart Problems
Y N High Blood Pressure
Y N Heart attack
If yes, Date_____
Y N Pacemaker
If yes, Date Placed_____
Y N Angina/Chest Pain
Y N Congestive Heart Failure
Y N Stents Placed
If yes, Dated Placed_____
Y N Cardiac shunt
Y N Artificial Heart Valves
If yes, Date Placed_____
Y N Mitral Valve Prolapse
Y N History of Infective Endocarditis
Y N History of anaphylaxis
Y N Other Heart Problems
Please List:_____
Y N Taking Blood Thinners
Y N History of Stroke
If yes, Date_____
Y N Anemia
Y N Sickle Cell Anemia
Y N Blood Clotting Disorder
Y N Circulatory Problems
Y N Bleeding Abnormally with Extractions
Y N Bruise Easily
Y N Swelling of Feet/Ankles/hands
Y N Other Bleeding Disorder
Please List:_____
Y N Cancer
Date of Diagnosis_____
Type of Cancer_____
Y N Chemotherapy
Y N Radiation Location:_____
Y N Immunotherapy
Y N Surgery related to the cancer
Y N In Remission
Y N AIDS/HIV
Y N Artificial Joints
Joint Replaced:_____
date of replacement:_____
Y N Epilepsy/Seizures
Y N Have you received an Organ Transplant
Please List date of transplant and the organ
_____
Y N Have you donated an organ
Y N Osteoporosis.
Y N If yes, do you receive yearly injections for this?

Y N Kidney Problems
Y N Dialysis
Y N Liver Problems
Y N Hepatitis (__Hep A __Hep B __Hep C)
Y N Stomach/Intestinal problems
Y N Acid Reflux/GERD
Y N Venereal Disease
Y N Respiratory Disease (Emphysema/COPD)
Y N Sleep Apnea
Y N Asthma
Y N Shortness of Breath
Y N Persistent or Bloody Cough
Y N Tuberculosis
If yes, when _____
Y N Scarlet Fever
If yes, when _____
Y N Rheumatic Fever
If yes, when _____
Y N Diabetes (__Type I __Type 2)
Y N High Cholesterol
Y N Thyroid Problems
Y N Swollen Neck Glands
Y N Arthritis
Y N Cortisone treatment/Long Term Steroid Use
Y N Sinus Problems
Y N Cold Sores/Fever Blisters
Y N Headaches
Y N Vertigo
Y N ADD/ADHD
Y N Developmental Disabilities
If yes, please explain:_____
Y N Post Traumatic Stress Disorder
If yes, what triggers symptoms?_____
Y N Anxiety Disorder
Y N Psychiatric Care
Y N Taking Antidepressants
Y N Bi-Polar
Y N Chemical Dependency/Drug Addiction
Y N Alzheimer's Disease/Dementia
Y N Schizophrenia
Y N Do you have any other medical conditions not listed
Please Describe: _____
_____
_____


# Assignment and Release

I hereby authorize payment directly to **Pruitt & Earp Dentistry** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/ or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Signature of Responsible Party Date

# Notice of Privacy Act Acknowledgment Form

This form acknowledges receipt of our Notice of Privacy Policy Practices and to document our efforts to obtain that acknowledgment.

In signing this agreement I understand and agree with the privacy practices of this office.

_____

Name of Patient (Please Print) Date

_____

Signature of Patient or Guardian Date
(If patient is under the age of 18, a parent or guardian must sign.)

PRUITT & EARP DENTISTRY
FAMILY, COSMETIC & IMPLANT DENTISTRY

## Effective Date: JUNE 8TH, 2022

# 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. Ryan Pruitt 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 Ryan T Pruitt, DMD 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 Ryan T Pruitt, DMD 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.


# Cancellation and No Show Policy

As an active patient at Pruitt & Earp Dentistry, I understand that I am responsible to cancel or reschedule appointments within 24 hours of the scheduled appointment time. We understand that schedules can change and unforeseen events will occur. If this should happen and you do need to cancel or reschedule, please give our office the courtesy of a phone call to inform us.

Please read below in regards to our No Show Policy and sign at the bottom of the form. If you have questions please let us know:

- A 24 hour notice is required to cancel/reschedule any appointment. Failure to cancel/ reschedule an appointment within 24 hours of the scheduled appointment time is considered a No Show.
- The patient will be expected to cancel/reschedule an appointment 24 hours in advance by telephoning **(NOT TEXTING)** Pruitt & Earp Dentistry **DURING REGULAR OFFICE HOURS.** Our business hours are Monday-Thursday 8am-4pm.
- A No Show will result in a $50 fee that is not covered by your insurance and MUST be paid prior to your next appointment. This fee will apply for each No Show.
- Failure to cancel an appointment due to hospitalization or adverse weather conditions will NOT be considered as failure to cancel an appointment.
- Pruitt & Earp Dentistry reserves the right to terminate a patient from our care after 3 documented No Show appointments within a 12 month period.
- Prior to termination, a letter will be sent to the patient explaining the reason for the termination.
- Appointment reminders are sent out via email and text messaging. If your appointment has not been confirmed through email or text, you will receive a reminder call from our office. This is a courtesy that we provide our patients and it does not relieve the patient from their responsibility to arrive on time for scheduled appointments.

I have read and understood Pruitt & Earp Dentistry's No Show Policy as listed above. I agree to comply with the listed No Show Policy and a copy of this policy has been given to me for my personal records and reference.

_____

Name (Printed) Date

_____

Signature

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# MEDICAL RECORDS TRANSFER

Date:_____

Patient Name:_____ DOB:_____ Phone Number:_____

**Records Sent to:**

Pruitt & Earp Dentistry
2446 Emerald Place
Greenville, NC 27834

**Records Sent from:**

_____
_____
_____

**Medical History**

_____ Last Recall Appointment

_____ Last Office Visit

_____ Last Bitewing Series

_____ Last Panorex

Pre-medications Needed:_____

Allergies:_____

Other:_____

_____

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

_____ _____
Signature of Patient or Legal Guardian Date

PRUITT & EARP DENTISTRY

FAMILY, COSMETIC & IMPLANT DENTISTRY

# Patient Photo Release Form

I hereby authorize Pruitt & Earp Dentistry or any of their assignees to take photographs and/or videos of my face, jaws, and teeth.

I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in demonstrations, lectures, advertising (including website publication, social media and television), and professional publications (dental magazines and journals).

I further understand that if the photographs and/or videos are used in any publication or as a part of a demonstration, my name (FIRST NAME ONLY) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

**Please initial:**

_____ I do not mind if my first name, face and teeth are used in any of the above stated situations.

**Exceptions:**

_____ I do not wish to have my First Name shown, or released.

_____ I do not wish to have my face shown.

_____ I only agree to have my teeth shown without any identifying features.

_____ I do not wish to have my photos used at all.

Patient Name _____

Patient/Guardian Signature _____

Date _____