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.

Patient Information

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? _____

Preferred Method of Contact (mark all that apply): ___Home phone ___Cell phone ___Email

Emergency Contact: _____ Phone _____ Relation to you: _____

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 oral or IV medications containing bisphosphonates (Typically for osteoporosis)? 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: _____

_____

_____

Pruitt & Earp Dentistry

FAMILY, COSMETIC & IMPLANT DENTISTRY

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.)

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Effective Date: December 12, 2006
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 WRITING to our Privacy Officer.

B. Right to Amend: If you feel the information collected about you is incorrect you may REQUEST 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: Pruitt & Earp Dentistry 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 Pruitt & Earp Dentistry 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 Pruitt & Earp Dentistry 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.

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Financial Policy

We appreciate the opportunity to serve you! We've found that a clear understanding of our financial policy in advance of dental care helps relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you may have. We will do our best to answer them for you.

- **Patients without insurance coverage need to know…** The fee for the treatment rendered must be paid in full on the day of service.
- **Patients with insurance coverage need to know…** The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that that you are ultimately responsible for all fees generated by your treatment.

- **We accept Visa, MasterCard, Care Credit, Checks, and cash for payment of the amount due. You can call us and put deposits down on your account to build credits.**

- **24-hour notice is required for rescheduling appointments**. A $50, $75, or $100 fee will be applied to your account depending on the type of appointment being cancelled, canceling, or failing to show up for your appointment without 24-hour notice. Both Dr. Pruitt and Dr. Earp understand that unforeseen circumstances may prevent you from attending your scheduled appointment, however, you must not make missing appointments a habit. Dr. Pruitt and Dr. Earp reserve your appointment time exclusively for you so please be mindful and considerate of this.

This is an agreement between Pruitt & Earp Dentistry, as the creditor, and the Patient/Debtor named on this form. By carrying out this agreement, you consent to treatment by Pruitt & Earp Dentistry and their staff and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

The Financial Policy continues on the next page.

Patient's Name: _____

Responsible part (if patient is under 18 years old): _____

Signature: _____ Date: _____

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Financial Policy Continued

In this agreement the words "you" "your" and "yours" mean the Patient/Debtor. The word "account"

Means the account that has been established in your name to which charges are made, and payments credited the words "we", "us", and "our" refer to Pruitt & Earp.

Treatment Plans: You understand that if Pruitt & Earp Dentistry has treatment recommendations for, you will receive an itemized list of the recommend treatment. This will also contain an estimate of what the fees will be for the recommended treatment. If you have dental insurance the estimate may include an additional estimate calculating what may be paid by your insurance company toward the fees for your treatment. You understand that treatment plan estimates are not a guarantee of insurance payment, and you are ultimately responsible for all fees generated by your treatment. Please be advised that your treatment plans are only valid for 90 days.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when a statement is issued and is overdue if not paid by twenty-one (21) days after the statement date.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all the collection costs that are incurred. If we must refer to collections of the balance to a lawyer, you agree to pay all lawyers' fees that we incur plus all court cost. In case of suit, you agree the venue shall be in Pitt County, North Carolina.

Returned Checks: There is a Fee (currently $25) for any checks returned by the bank.

Treatment at Other Offices: Please be advised that when you are referred/ go to a specialist for other services, we do guarantee payment from insurance. This is caused by us not knowing what claims may be pending at the other offices, ultimately resulting sometimes in nonpayment for services provided in our office.

Insurance: Insurance is a contract between you and your insurance company. We will bill your insurance company as a curtesy to you. Please note that services are not rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment of all fees generated by your treatment. If your insurance company has not paid your claim within ninety days after the service, the full amount is due and payable by you. We will promptly refund any insurance payments to you we receive if you have already paid the balance to your account. It is your responsibility to inform us of any changes in your insurance coverage.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Change of Treatment: If your treatment is changed on the day of your appointment without a 3-day's notice, there will be a charge added to the account for the treatment that is not provided. This amount ranges between $50-100 depending upon the treatment that was initially scheduled. Ex: If you plan to have a Crown, Core Build Up and Resin scheduled and the day of the appointment you decide at check in you would like only to have the Resin, then this would result in a charge for canceling the other services.

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MEDICAL RECORDS TRANSFER

Date:_____

Patient Name:_____ DOB:_____ Phone Number:_____

Records Sent to:	Records Sent from:
Pruitt & Earp Dentistry	_____
2446 Emerald Place	_____
Greenville, NC 27834	_____

Dental 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

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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 _____