Personal Information

This personal information will help us to give you the most consideration of your time and feelings. It is important to have complete answers. All information is, of course, confidential.

Patient's name: _____Nickname:_____ Date of Birth: _____/_____/_____
Parents' names: _____Home Phone :(_____) _____ Grade: _____
Address: _____City, State, Zip_____
Dad's Employer: _____Dad's SSN: _____/_____/_____ Dad's Birth date: ____/____/___
Mom's Employer: _____Mom's SSN: _____/_____/_____Mom's Birth date: ____/____/____
Dad's work#: (_____) _____ Mom's work#: (_____) _____ Cell# :(_____) _____
Prescription drug card? Yes○No○Dental Insurance? Yes○No○ Is dental coverage thru dad, mom, or both? _____
If both, whose is primary? _____Primary Insurance Co.: _____ID #_____
Secondary Insurance Co.: _____ID #_____
Emergency contact name: _____Phone #: (_____) _____ Relationship: _____

Health History

Medical doctor: _____City:_____ Date of last medical check-up: _____
General health problems within the past 5 years? (Serious illness, hospitalization, surgery) _____
_____ Are you under a physician's care now? _____
If so, for what? _____
Are you currently taking an antibiotic: _____ If so, please circle which one: Penicillin Cleocin Other: _____
What day did you start? _____What do you have available to take for pain? Ibuprofen (i.e. Advil, Motrin), Aspirin, Tylenol, Aleve, Pain Rx_____ Other: _____What other medications, vitamins, etc., do you take? _____
Which pharmacy do you prefer? _____Street/City: _____

OFFICE USE_____/_____ P_____

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

Please check YES or NO. If YES, please CIRCLE disease or problems:

	Yes	No
Rheumatic fever, rheumatic heart disease, heart murmur	○	○
Pacemaker (Date Placed ___/___/_____)	○	○
Heart trouble, heart attack; stroke	○	○
Pain in chest, shortness of breath, swollen ankles	○	○
Mitral valve prolapse	○	○
High blood pressure (Controlled? Yes or No)	○	○
Low Blood Pressure, faint easily, dizziness	○	○
Blood disorders, anemia, or sickle-cell anemia	○	○
Blood test with unusual result or venereal disease	○	○
HIV positive, ARC, or AIDS	○	○
Abnormal bleeding, prolonged healing, easily bruised	○	○
Asthma, sinus infections, hay fever	○	○
Thyroid disease or deficiency	○	○
Seizures, epilepsy	○	○
Alcoholism, drug abuse	○	○
Hepatitis, jaundice, liver disease	○	○
Arthritis Mild / Moderate / Severe	○	○
Prosthetic joint Knee / Hip / other	○	○
Kidney troubles	○	○
Tuberculosis, other lung ailments (Smoker? Yes / No)	○	○
Persistent cough, cough up blood	○	○
Diabetes (Controlled by Insulin / Oral / Diet)	○	○
Radiation treatment for a tumor or other growth	○	○
Sores that did not heal within one-week	○	○
Women: Are you pregnant?	○	○
Are you taking birth control pills?	○	○
Are you prone to yeast infections?	○	○

Sensitive to, allergic to, or avoid:

	Yes	No
Penicillin	○	○
Cleocin/Clindamycin	○	○
Flagyl/Metronidazole	○	○
Erythromycin	○	○
Tetracycline	○	○
Sulfa	○	○
Aspirin	○	○
Tylenol	○	○
Ibuprophen	○	○
Codeine	○	○
Latex	○	○
Local Anesthetics	○	○
Non-precious metals	○	○
Milk Intolerance	○	○
Other Drugs	○	○

_____

Do you have any disease, condition, or problem not listed above that you think the doctor should know about? ___ ___

_____

_____

_____ **X**_____

Date Parent's Signature

ENDODONTIC ASSOCIATES OF NWO, LLC

715 North Dixie
Wapakoneta, Ohio 45895-7749

Insurance Authorization

The undersigned hereby authorized the insurance manager of Endodontic Associates of NWO, LLC as the undersigned's attorney-in-fact, to apply for, collect and apply the undersigned's account with Endodontic Associates of NWO, LLC, any amount payable to or for the benefit of the undersigned or any member of the undersigned's family under any contract of insurance covering such person for any service performed at the office of Endodontic Associates of NWO, LLC, for such person. Our office does **NOT** participate with **ANY** insurance companies. This means our office is non-participating. There is no negotiation of fees and there is not a write off for a negotiated amount. If there is a remainder balance after the insurance pays toward your visit then you are responsible for the difference of what is paid today and the remainder amount. This authorization shall remain in force and effect until written notice of its revocation is received by the office of Endodontic Associates of NWO, LLC.

Financial Responsibility

I understand that Endodontic Associates of NWO, LLC works on a cash basis. If I request that this office submit the charges for treatment to my insurance company to cover a portion of my bill, I understand that I am ultimately responsible for those charges. I understand that this office may request that I pay all or a portion of my bill at the time of service based on past experience with the insurance company. I understand that a requested down payment is **estimation only** and should not be relied upon as a guarantee of remaining payment from my insurance company. If my insurance fails to pay within 30 days of my treatment or if there is a balance due after insurance pays I agree to pay said balance within 10(ten) days.

Accounts unpaid after this time are subject to a 2% per month finance charge (24% annually).

___/___/___ **X**_____
Date Patient Signature (Parent if patient is a minor)

Acknowledge of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I have been offered a copy of this office's Notice of Privacy Practices.

___/___/___ **X**_____
Date Patient Signature (Parent if patient is a minor)

Endodontic Associates of NWO, LLC
Grace S. Evans, DMD
Philip B. Mikesell, DDS
Amy B. Forloine, DDS
715 North Dixie Wapakoneta, Ohio 45895-0024

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 04/14/03 and will remain in effect until we replace it.

We reserve the right to change our policy 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 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 this 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 t for 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 you 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 you 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 prescription, medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communication 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 or 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 us or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards or letters.)

(OVER)

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 $1.00 for each page and $0.00 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. 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: Your 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 payment 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 email) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our policy practices or have any 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 location, you may complain to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 chose to file a complaint with us or with the US Department of Health and Human Services.

Contact Officer: Shannon U.
Phone:419-738-6944