PATIENT # ______________

PATIENT INFORMATION

CONFIDENTIAL

DATE ______________

(PLEASE PRINT)

NAME ______________ (FIRST / MI / LAST) BIRTHDATE ______ HOME PHONE ______

ADDRESS ______________ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

E-MAIL ______________ CELL PHONE ______

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER ______________ WORK PHONE ______

BUSINESS ADDRESS ______________ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

SPOUSE OR PARENT/GUARDIAN'S NAME ______ EMPLOYER ______ WORK PHONE ______

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE ______ CITY ______ STATE/PROV. ______

WHOM MAY WE THANK FOR REFERRING YOU? ______________

PERSON TO CONTACT IN CASE OF AN EMERGENCY ______________ PHONE ______

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______ RELATIONSHIP TO PATIENT ______

ADDRESS ______________ HOME PHONE ______

E-MAIL ______________ CELL PHONE ______

DRIVER'S LICENSE # ______ BIRTHDATE ______ FINANCIAL INSTITUTION ______

EMPLOYER ______________ WORK PHONE ______

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______________ RELATIONSHIP TO PATIENT ______

BIRTHDATE ______ SS #/SIN ______ DATE EMPLOYED ______

NAME OF EMPLOYER ______________ WORK PHONE ______

ADDRESS OF EMPLOYER ______ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

INSURANCE COMPANY ______ GROUP #______ UNION OR LOCAL # ______

INS. CO. ADDRESS______ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX. ANNUAL BENEFIT? ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ______________ RELATIONSHIP TO PATIENT ______

BIRTHDATE ______ SS #/SIN ______ DATE EMPLOYED ______

NAME OF EMPLOYER ______________ WORK PHONE ______

ADDRESS OF EMPLOYER ______ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

INSURANCE COMPANY ______ GROUP #______ UNION OR LOCAL # ______

INS. CO. ADDRESS______ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX. ANNUAL BENEFIT? ______

SIGNATURE

X ______________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

Patterson #053-0246

PATIENT NAME ______________________ TODAY'S DATE ______________

HOME ADDRESS ______________________ DATE OF BIRTH ______________

______________________ HOME PHONE ______________

E-MAIL ______________________ CELL PHONE ______________

BUSINESS ADDRESS ______________________ BUSINESS PHONE ______________

______________________ SS #/SIN ______________

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN ______________ OFFICE PHONE ______________ DATE OF LAST EXAM ______________

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? ______________		
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
5. DO YOU USE TOBACCO?	☐	☐
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (E.G. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER ______
☐	☐	SULFA DRUGS	☐	☐	IODINE			______

	YES	NO
9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES
☐	☐	FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER ______
☐	☐	THYROID PROBLEM	☐	☐	STOMACH TROUBLES / ULCERS			______

COMMENTS

____

____

____

____

SIGNATURE OF DENTIST DATE

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X ______________________ ______________

PATIENT, PARENT OR GUARDIAN DATE

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 01-01-2003, 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 $0.50 for each page, $10.00 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, 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 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.

Contact Officer: Eric S. Browning, DMD, MS

Telephone: 765-289-48667 Fax: 765-289-5751

E-mail: contactus@browningperiodontics.com

Address: 610 South Tillotson Avenue Muncie, IN 47304

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Browning Periodontics

Financial Menu

Thank you for choosing Eric S. Browning, DMD, MS for your dental care. Our goal for our patients is to experience a pleasant dental environment, while providing the finest dental care available. This menu was designed to help you understand our financial, appointment and insurance policies.

Payment

Payment is expected the day the dental services are provided. For your convenience MasterCard, Visa, Discover, debit cards, checks and cash are accepted. We will inform you of your dental fees and estimated payments due to begin treatment as needs are diagnosed.

Dental Insurance

If you have the benefit of dental insurance, we accept most plans that do not require a specific provider. Please bring your Dental Insurance card and any benefit information you have to your first appointment. Dental insurance is not intended to be a "pay-all" service, but help to lower out-of-pocket expenses. As a courtesy, we will file your dental insurance claims. Please be prepared to pay your deductible and any estimated co-payment in full as services are rendered. Our office is willing to wait up to 30 days from the date of service for your insurance to respond. Any balance aging beyond 30 days is due in full by the patient/responsible party. We will make a request for your insurance to reimburse the patient/responsible party directly.

Appointments

We see patients on a "pre-reserved appointment basis" and ask that you call in advance for a reserved time in our practice. We value our patients busy schedules and strive to see patients at their appointed times; we ask you to extend the same courtesy. **If you experience a scheduling conflict with a reserved appointment, please provide at least 48 hours advance notice.** This notice provides an opportunity to serve others who are in need of periodontal care. **In instances where appointments are cancelled or failed with 48-hours notice or less, a missed appointment fee of at least $30.00 and up to 10% of surgery fee will be charged to your account.** This fee will not be filed with insurance and it is payable in full prior to scheduling the next dental visit. Your assistance with this matter is greatly appreciated.

Returned Check Fee

A fee of $25.00 will be charged for any returned check. The entire outstanding account balance must be paid in full prior to scheduling the next dental visit.

Acknowledgement and Authority

I consent to treatment as necessary or desirable for the patient named, including but not restricted to drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies by the attending Doctor, staff or qualified designate. I authorize, Dr. Eric S. Browning, DMD, MS to release any information to a third party and/or health practitioners. I authorize and request my insurance company to pay Dr. Eric S. Browning, DMD, MS directly, otherwise payable to me. I understand my insurance carrier may pay less than the total bill for services and unconditionally agree to be responsible for, and to pay all charges incurred on my behalf or my dependants. I agree and understand in the event of default payment to Dr. Eric S. Browning, DMD, MS of the balance due, and my account is placed in the hands of a collection agency and/or Attorney for collection proceedings, I will be legally responsible for all Attorney/collection fees equal to thirty (30%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account plus any applicable court cost, collection cost, consideration for assignment, litigation expenses, as well as any other incidental expenses incurred by Eric S. Browning, DMD, MS and /or assignees. I agree to pay Eric S. Browning, DMD, MS, a minimum fee of $30.00 for any appointment I schedule and fail to arrive in a timely manner or cancel with less than 48 hours advance notice. The information I have given today is correct to the best of my knowledge. I also understand this information will be held in confidence and it is my responsibility to inform Eric S. Browning, DMD, MS of any changes in my personal or medical status. I authorize Eric S. Browning, DMD, MS or qualified designate to perform dental services that I may need during diagnosis and treatment with my informed consent. If the patient is a minor, I certify I am the legal guardian.

Patient Name____________________________________ **Date**__________

Signed ____________________________________ **Date**__________

My signature listed above confirms I am legally the Responsible Party, Parent or Authorized Guardian for the patient.