DR.W. SCOTT HENDRICKS D.D.S.

Exceptional Dentistry for Exceptional People

Patient Information

Patient Birthdate__/__/__ Today's Date __/__/__

Title: ○ Dr. ○ Miss ○ Mr. ○ Mrs. ○ Ms.

First ________________ Middle________________ Last_________________

Address____

City_________________________ State______ Zip ____________

Telephone: Home ________________ Work ________________ Ext. ________

Cell ________________ Email: _________________

How would you like appointment reminders? ○ Text ○ Email ○ Phone ○ Mail

How did you find us? ____

Gender: ○ Female ○ Male Status: ○ Child ○ Married ○ Single

Social Security Number ____-____-______ (Parent's SS# if Minor Child)

Occupation________________ Employer_____________________

Emergency Contact:

Name____________________ Relationship______________________

Telephone Number _________________

Address____

City_________________________ State______ Zip ____________

Financial Responsibility Information for Dr. W. Scott Hendricks, D.D.S.:
I understand that I am responsible for all fees incurred regardless of insurance coverage.

X____

Signed (Patient or Parents of Minor Child)

Health History

Please check if you have or have you ever had the following:

___High Blood Pressure	___Cardiac Pacemaker
___Heart Problem	___Mitral Valve Prolapse
___Infective Endocarditis	___Leaky Heart Valve
___Artificial Heart Valve	___Asthma
___Epilepsy	___Diabetes
___Systemic Lupus	___Radiation Therapy
___Bleeding Problems	___HIV or AIDS
___Attention Deficit Disorders	___Hemophilia/Blood Disorders
___Prolonged Healing	___Fibromyalgia
___Hepatitis	___Stroke
___Immunosuppression	___Thyroid Problem
___Do you Smoke?	___Glaucoma
___Do you have Ear Pain?	___Rheumatoid Arthritis
___Bloody Sputum	___Night Sweats
___Weight Loss	___Anorexia
___Fever	___Women, are you pregnant?

___A Prolonged Cough Lasting 3 Weeks or Longer

___Artificial Joints: If yes, when? ______________________________

___Infected Artificial Joint If None of the Above, Please Initial Here ____

Has your doctor told you that you need a premedication prior to dental work? ____

Please List All Current Medications ______________________________________
____

Please List All Food Allergies____
____

Please List All Allergies to Metals ____
____

Please List All Medication Allergies____
____

Are You Allergic to Latex? __________

Physician's Name _________________ Telephone ___________________

I Am Interested In:

○ Professional Whitening ○ Veneers ○ Straighter Teeth

○ Home Whitening ○ DentalSpa ○ Oral HPV Screening

Family Health History

Please indicate which family members (blood relatives only) have the following medical conditions (Mother, Father, Siblings, Children):

High Blood Pressure ____

Heart Disease ____

Stroke ____

Diabetes ____

Rheumatoid Arthritis ____

Alzheimer's Disease ____

Insurance Information

Insurance Subscriber Name:

First ________________ Middle________________ Last________________

Insurance Subscriber Birthdate__/__/__

Subscriber Relationship to Patient:

○ Self ○ Husband ○ Wife ○ Mother ○ Father

Subscriber Social Security Number ___-___-____

Insurance Company Name ____

Group Plan Name ____

Subscriber ID ____

Insurance Company Address ____

City_________________________ State______ Zip ____________

Insurance Company Telephone Number _________________________________

AUTHORIZATION TO PAY BENEFITS:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF DR. W. SCOTT HENDRICKS, D.D.S. FOR SERVICES RENDERED. I UNDERSTAND I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.

X____

Signed (Patient or Parents of Minor Child)

Your signature will be maintained as 'signature on file' so that you do not have to sign insurance forms after each visit.

Welcome to Our Practice!

Printed on 100% Post-Consumer Recycled Paper

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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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Dr. W. Scott Hendricks, D.D.S.

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 01/01/10, 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, letters, email or by text messages.

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 may 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 may charge you $.25 for each page, $30.00 per hour for staff time to 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: Patty Hendricks

Telephone: (330) 877-9281 FAX: (330) 877-3579

E-mail: drwshendricks@gmail.com

Address: Dr. W. Scott Hendricks, D.D.S. 140 Grand Trunk Avenue Hartville, Ohio 44632

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