Amy M. Gerardot, D.D.S.

The Place Where Muncie Smiles

Thank you for selecting us as your dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form thoroughly. If you have any questions or need assistance, please ask us – we will be happy to help.

About You

Last:_____ First:_____ MI:____ I prefer to be called:_____ Today's Date: ____/____/_____

Birth date: _____/_____/_____ Age:_____ SS#:_____ Gender: ❍M ❍F Marital Status: ❍Single ❍Married ❍Divorced ❍Widowed ❍Separated

Address:_____ City:_____ State:_____ Zip:_____ Apt.#_____

Email:_____ Home #: _____ Cell #: _____

Patient's Employer_____ How Long There?:_____ Work #: _____ Ext.:_____

Employer Address:_____ City:_____ State:_____ Zip:_____ Occupation:_____

Spouse's Name: _____ Spouse's Employer: _____ Spouse's Work #: _____ Ext.:_____

Whom may we thank for referring you?_____ Other Family Seen At Our Office:_____

Insurance

Name of Insured: _____ Relation to Patient:_____

Insured's Birth date: _____/_____/_____ Insured's SS#:_____ Insured's Employer:_____

Insurance Co.:_____ Insurance Co. Phone #:_____

Insurance Co. Address:_____ City:_____ State:_____ Zip:_____

Identification/Member #:_____ Group #:_____ Payor ID#_____

Secondary Insurance

Name of Insured: _____ Relation to Patient:_____

Insured's Birth date: _____/_____/_____ Insured's SS#:_____ Insured's Employer:_____

Insurance Co.:_____ Insurance Co. Phone #:_____

Insurance Co. Address:_____ City:_____ State:_____ Zip:_____

Identification/Member #:_____ Group #:_____ Payor ID#_____

Contact Preferences

It is our pleasure to provide a reminder of your future appointments. Please let us know your preferences in regards to contacting you.

How Do You Prefer To Receive Reminders?

❍ Home # ❍ Work # ❍ Cell #

❍ Text Message to Cell #

❍ Email ❍ No Reminder

❍ May we leave a voice mail or message if you are not available

Best Times/Phone # To Reach You During Day:

Times:_____

Phone #(_____)_____

Person/Phone # To Contact In Case Of Emergency:

Name:_____

Relation:_____

Phone #(_____)_____

I understand that my claims will be filed to my insurance company but the contract is between my insurance company and me. Dr. Amy Gerardot has no contracts with my insurance company. Submission of claims is not a guarantee of payment, and I am ultimately responsible for full payment to Dr. Amy Gerardot.
In consideration of the services to be provided to the patient, I hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of service or, if no such arrangements are made, then payment shall be made in full within thirty (30) days of service. I agree that in the event of default in payment, reasonable collection agency fees equal to up to fifty (50%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

Signature_____ Date_____

3909 N. Wheeling Ave • Munice, IN 47304
Phone: (765) 288-1475 • Fax: (765) 289-3584 • Email: munciesmiles.com@gmail.com

Please complete both sides

Medical History

Do you have a personal physician? Yes ❍ No ❍

If yes, what is your physician's name _____ Phone#:_____ Date of Last Visit:_____

Your current Physical Health is Good ❍ Fair ❍ Poor ❍

Are you taking any prescription/over-the-counter medications? Yes ❍ No ❍

Please list each one: _____ _____

_____ _____

Do you or have you have you had any of the conditions below:

	Y	N	If yes, please provide date/details		Y	N	If yes, please provide date/details
Abnormal Bleeding	❍	❍	_____	Hepatitis	❍	❍	_____
Alcohol/Drug Abuse	❍	❍	_____	Herpes/Fever Blisters	❍	❍	_____
Anemia	❍	❍	_____	High Blood Pressure	❍	❍	_____
Arthritis	❍	❍	_____	HIV+/AIDS	❍	❍	_____
Artificial Bones/Joins/Valves	❍	❍	_____	Hospitalized for any reason	❍	❍	_____
Asthma	❍	❍	_____	Kidney Problems	❍	❍	_____
Blood Transfusion	❍	❍	_____	Liver Disease	❍	❍	_____
Cancer/Chemotherapy	❍	❍	_____	Low Blood Pressure	❍	❍	_____
Colitis	❍	❍	_____	Mitral Valve Prolapse	❍	❍	_____
Congenital Heart Defect	❍	❍	_____	Pacemaker	❍	❍	_____
Diabetes	❍	❍	_____	Psychiatric Problems	❍	❍	_____
Difficulty Breathing	❍	❍	_____	Radiation Treatment	❍	❍	_____
Emphysema	❍	❍	_____	Rheumatic/Scarlet Fever	❍	❍	_____
Epilepsy	❍	❍	_____	Seizures	❍	❍	_____
Fainting Spells	❍	❍	_____	Shingles	❍	❍	_____
Frequent Headaches	❍	❍	_____	Sickle Cell Disease/Traits	❍	❍	_____
Glaucoma	❍	❍	_____	Sinus Problems	❍	❍	_____
Hay Fever	❍	❍	_____	Stroke	❍	❍	_____
Heart Attack	❍	❍	_____	Thyroid Problems	❍	❍	_____
Heart Murmur	❍	❍	_____	Tuberculosis (TB)	❍	❍	_____
Heart Surgery	❍	❍	_____	Ulcers	❍	❍	_____
Hemophilia	❍	❍	_____	Venereal Disease	❍	❍	_____

Please list any serious medical condition(s) that you have ever had:_____

_____

_____

Are you allergic to any of the following?

Aspirin	Yes ❍ No ❍	Erythromycin	Yes ❍ No ❍	*Metals*	Yes ❍ No ❍
Codeine	Yes ❍ No ❍	Jewelry	Yes ❍ No ❍	*Penicillin*	Yes ❍ No ❍
Dental Anesthetics	Yes ❍ No ❍	Latex	Yes ❍ No ❍	*Tetracycline*	Yes ❍ No ❍

Dental History

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? Yes ❍ No ❍ Are you currently in pain? Yes ❍ No ❍

Have you ever had a serious/difficult problem associated with any previous dental work? Yes ❍ No ❍

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJTMD)? Yes ❍ No ❍

Your current dental health is Good ❍ Fair ❍ Poor ❍ Do your gums bleed? Yes ❍ No ❍

How many times a week do you brush? _____ How many times a week do you floss ? _____

Amy M. Gerardot, DDS

Health Insurance Portability Act Acknowledgement Form (HIPAA)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers (insurance companies).

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Amy M. Gerardot DDS, PC

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 that are described in this Notice while it is in effect. This Notice takes effect 4/14/2003, 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 DISCLOSURE 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. Computers are located throughout our practice. They prove to be an essential part of delivering high quality dental care to our patients. We use the computer to communicate to both patients and to staff. Schedules are posted on the computer throughout our practice with the day's schedule and the patient's proposed treatment in order to achieve effective communication and high quality dental care.

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 make 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 of your healthcare, but only if you agree that we may do so.

Person 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, or you location, your general condition or death. If you 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, e-mail, or text message)

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. If you request copies, we reserve the right to charge you a fee 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 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 diclosre of your helath information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contatct 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 ot 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: Amy M. Gerardot, DDS

Telephone: 765-288-1475 Fax: 765-289-3584

E-mail: munciesmiles.com@gmail.com

Address: 3909 N. Wheeling Ave. Muncie, IN 47304