Jeffrey R. Eby, D.M.D.
Family and Cosmetic Dentistry
240 North Seventh Street, Suite 400
Akron, PA 17501

Patient Registration:

First Name:________________________Last Name:______________________Middle Initial:________
Preferred Name:___________________Birth Date:____________________Age:______Sex:________
SS#:_______________Marital Status:_______Referred By:_______________________________________
Address:____Apt#:________________
City:____________________________State:_________Zip Code:_____________________________
Home Phone:_________________Cell phone:_________________Work Phone:_________________
How would you like to be contacted to confirm your dental appointments: Text☐ Email☐Phone Call☐
Email:_______________________________Person financially responsible for account:____________
Employer:______________________Occupation:_______________________________________
Do you have dental Insurance?☐Yes☐No Insurance Company:______________________
Policy Holder:_____________________________Policy Holder DOB:_____________________
Group #:_____________________________ID#:____________________________________
Do you have a secondary dental insurance? ☐Yes☐No Insurance Company:__________________
Policy Holder:_____________________________Policy Holder DOB:_____________________
Group #:_____________________________ID#:____________________________________

Consent for Dental Treatment:

You have the right to accept or reject dental treatment recommended by Dr. Eby. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure. You should also be knowledgeable about alternative treatments or the option of no treatment. Do not consent to treatment until you discuss potential benefits, risks, and complications with Dr. Eby and all of your questions are answered. It is very important that you provide your dentist with accurate information about your health and your dental treatment before, during, and after treatment and is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Please read and initial the items below and sign at the bottom of the form.

Please read and initial all of the items below and sign at the bottom of the form.

1. I authorize Dr. Eby and his staff to perform or assist in the performance of dental treatment including but not limited to routine procedures, extra oral pictures, radiographs, prophylaxis, fillings, etc.
_________Patient Initials

2. I understand that antibiotics, analgesics, and other medications may be prescribed as a part of dental treatment. I agree to follow Dr. Eby's prescription orders and to make Dr. Eby and his staff fully aware of any allergies that I knowingly have and any reactions I have to medications he prescribes.
_________Patient Initials

3. I understand that during treatment it may be necessary to change or add dental procedures because of conditions found while working on the teeth, the most common being root canal therapy. I give permission to Dr. Eby to make any additional changes as necessary.
_________Patient Initials

I HAVE FILLED OUT THE PATIENT REGISTRATION TO THE BEST OF MY KNOWLEDGE AND I HAVE READ AND UNDERSTAND THE ABOVE CONSENT FOR DENTAL TREATMENT.

____
PRINT PATIENT NAME

______________________________________ ____________________________
SIGNATURE OF PATIENT/GUARDIAN TODAYS DATE

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Health Information:

Physicians Name:____________________ Phone number:________________

Are you currently under the care of a physician? ☐Yes☐No

Have you ever been hospitalized or had a major operation? ☐Yes☐No

If yes, please describe:____________________________

Have you ever had a serious head or neck injury? ☐Yes☐No

Are you taking any medications, pills or drugs? ☐Yes☐No--If yes please provide a complete list:

____

____

____

Do you have any allergies or unusual reactions to food, medications, the environment, etc...? ☐Yes☐No

If yes please provide a complete list:

____

Do you/have you ever taken Phen-fen or Redux? ☐Yes☐No

Have you ever taken Fosamax, Boniva, Actonel, or any other bisphosphonate medications? ☐Yes☐No

Are you on a special diet? ☐Yes☐No

Do you use tobacco products? ☐Yes☐No Do you use alcohol? ☐Yes☐No

Do you use controlled substances? ☐Yes☐No--If yes,____________________

WOMEN- Are you pregnant/trying to get pregnant?☐ Nursing?☐ Taking oral contraceptives?☐

Do you have or have you ever had any of the following?:

AIDS/HIV	☐Yes☐No	Excessive thirst	☐Yes☐No	Mitral Valve Prolapse	☐Yes☐No
Alzheimer's	☐Yes☐No	Fainting/Dizziness	☐Yes☐No	Osteoporosis	☐Yes☐No
Anaphylaxis	☐Yes☐No	Frequent Cough	☐Yes☐No	Pain in Jaw	☐Yes☐No
Anemia	☐Yes☐No	Frequent Diarrhea	☐Yes☐No	Parathyroid Disease	☐Yes☐No
Angina	☐Yes☐No	Frequent Headaches	☐Yes☐No	Psychiatric Care	☐Yes☐No
Arthritis (Gout)	☐Yes☐No	Genital Herpes	☐Yes☐No	Radiation Treatment	☐Yes☐No
Artificial Heart Valve	☐Yes☐No	Glaucoma	☐Yes☐No	Recent Weight Loss	☐Yes☐No
Artificial Joint	☐Yes☐No	Hay Fever	☐Yes☐No	Renal Dialysis	☐Yes☐No
Asthma	☐Yes☐No	Heart Attack/Failure	☐Yes☐No	Rheumatic Fever	☐Yes☐No
Blood Disease	☐Yes☐No	Heart Murmur	☐Yes☐No	Rheumatism	☐Yes☐No
Blood Transfusion	☐Yes☐No	Heart Pacemaker	☐Yes☐No	Scarlett Fever	☐Yes☐No
Breathing Problems	☐Yes☐No	Heart Trouble/Disease	☐Yes☐No	Shingles	☐Yes☐No
Bruise Easily	☐Yes☐No	Hemophilia	☐Yes☐No	Sickle Cell Disease	☐Yes☐No
Cancer	☐Yes☐No	Hepatitis A	☐Yes☐No	Sinus Trouble	☐Yes☐No
Chemotherapy	☐Yes☐No	Hepatitis B or C	☐Yes☐No	Spina Bifida	☐Yes☐No
Chest Pains	☐Yes☐No	Herpes	☐Yes☐No	Stomach/Intestinal Disease	☐Yes☐No
Cold Sores	☐Yes☐No	High Blood Pressure	☐Yes☐No	Stroke	☐Yes☐No
Congenital Heart disorder	☐Yes☐No	High Cholesterol	☐Yes☐No	Swelling of Limbs	☐Yes☐No
Convulsions	☐Yes☐No	Hives/rash	☐Yes☐No	Thyroid Disease	☐Yes☐No
Cortisone Medicine	☐Yes☐No	Hypoglycemia	☐Yes☐No	Tonsillitis	☐Yes☐No
Diabetes	☐Yes☐No	Irregular Heartbeat	☐Yes☐No	Tuberculosis	☐Yes☐No
Drug Addiction	☐Yes☐No	Kidney Problems	☐Yes☐No	Tumors/Growths	☐Yes☐No
Easily Winded	☐Yes☐No	Leukemia	☐Yes☐No	Ulcers	☐Yes☐No
Emphysema	☐Yes☐No	Liver Disease	☐Yes☐No	Venereal Disease	☐Yes☐No
Epilepsy/Seizures	☐Yes☐No	Low Blood Pressure	☐Yes☐No	Yellow Jaundice	☐Yes☐No
Excessive Bleeding	☐Yes☐No	Lung Disease	☐Yes☐No		☐Yes☐No

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Do you have any other medical conditions that were not previously asked about above? ☐Yes☐No
If Yes:____

____

____

____

____
PRINT PATIENT NAME

__________________________	____________________
SIGNATURE OF PATIENT/GUARDIAN	TODAYS DATE
__________________________	____________________
DOCTOR SIGNATURE	TODAYS DATE

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FINANCIAL POLICY

PATIENTS WITH DENTAL INSURANCE COVERAGE:

We will be happy to request a pre-estimate of benefits from your insurance carrier if you request us to do so. Routine treatment is generally performed without submitting a request for pre-treatment of benefits.

We will be glad to help you obtain the appropriate benefits from your insurance carrier and bill your carrier as a courtesy to you but we can NOT guarantee payment from them. You, the patient, are ultimately responsible for the balance and payments of your account.

If your insurance has not paid within 60 days of services rendered, you will need to make full payment to this office. You will be reimbursed when your insurance company pays.

Portions of the bill may not be paid by the insurance company and are to be paid by the person financially responsible for your account. We ask that all copays are taken care of at the time of service. If you are having treatment over a period of time, we appreciate payment during the course of treatment and before cases are sent to the laboratory. Our front office staff will assist you in arranging a payment schedule

PATIENTS WITHOUT DENTAL INSURANCE COVERAGE:

Patients without insurance coverage are requested to pay for services as they are rendered. We accept cash, check, MasterCard, Visa, Discover, and American Express. We also have flexible payment plan options through Care Credit. If you are interested in financing your dental treatment please ask the office staff for a Care Credit application. A fee of $25.00 may be charged for all returned checks.

In order to serve you better and keep the cost of dental care down, we try and maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least a 24-hour notice for any cancelled appointment. It is our policy to charge a missed appointment fee of $25.00 after the second missed or cancelled appointment.

We as a dental team are committed to providing the highest quality of oral health care. We do not want or expect you to postpone necessary treatment. We will do our best to work out financial issues so that you may continue your care with out any delay. Should you have any questions or concerns please speak with our front office staff BEFORE treatment is initiated.

Authorization/Release of Information:
I authorize payment directly to Dr. Eby for insurance benefits, otherwise payable to me for his services. I have reviewed the treatment plan and I authorize the release of any information relating to this claim, including x-rays, study models, photographs, etc.
I HAVE READ THE ABOVE AND UNDERSTAND THE FINANCIAL POLICY OF THE OFFICE OF DR. JEFFREY R. EBY.

____
PRINT PATIENT NAME

____________________________________ __________________________
SIGNATURE OF PATIENT/GUARDIAN TODAYS DATE

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

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:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify) ______________________

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to the information.

Please review 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 privacy practices and the terms of this notice at any time, provide 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 new 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.

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 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 or provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of your healthcare 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 a 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 your written permission, 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 Patients Right section of this notice. We may disclose your health information to a family member, friend, or other person to the extent if necessary to help with your healthcare or with payment for your healthcare, but <u>only</u> if you agree that we may do so.

Marketing Health-related Services: We will not use your healthcare 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.