Family Dental Care (FDC)

Dr. Nicole Stachewicz Johnson, D.M.D
4206 East Lake Road
Erie, PA 16511

Patient Information and Medical History

(Updated: August 21, 2012)

Date: _____ Home Phone: _____ Cell Phone: _____

Patient Name: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female D.O.B: ____/____/____ Social Security #____-____-____

Marital Status ☐ Married ☐ Single ☐ Child ☐ Other Drivers License #_____

Primary Dental Insurance

Subscriber Name: _____

Sex: ☐ Male ☐ Female D.O.B: ____/____/____ Social Security #____-____-____

Employer: _____ Phone: _____

Dental Insurance: _____ Group #_____ ID# _____

Secondary Dental Insurance

Subscriber Name: _____

Sex: ☐ Male ☐ Female D.O.B: ____/____/____ Social Security #____-____-____

Employer: _____ Phone: _____

Dental Insurance: _____ Group #_____ ID# _____

Health History

Do you now or have you ever had allergic or other adverse reactions to the following or any other medications:

☐ **NONE** ☐ Antibiotics ☐ Local Anesthetics ☐ Codeine
☐ Penicillin ☐ Latex ☐ Aspirin ☐ Other _____

Do you now have or ever had any of the following: ☐ None

☐ Heart Problems	☐ Artificial Heart Valves	☐ Heart Attack
☐ Pacemaker/Defibrillator	☐ Heart Transplant	☐ High Blood Pressure
☐ Low Blood Pressure	☐ Abnormal Bleeding	☐ AIDS/HIV positive
☐ Hepatitis	☐ Diabetes	☐ STD
☐ Tuberculosis	☐ Asthma	☐ Cancer
☐ Radiation Treatment	☐ Headaches	☐ Mental Disorders
☐ Pregnancy (are you currently)	☐ Total Joint Replacement	☐ Other _____

*Please present insurance cards and drivers license to receptionist.

Current Medications and reason for taking:

Primary Physician's Name
Are you currently under the care of a Physician? ☐ Yes ☐ No
If yes explain:
Is there anything else we should know about your medical history?

The above information is accurate and complete to the best of my knowledge. It will be considered confidential and will be used only in my treatment, billing, insurance-processing and for my own health. I will not hold the dentist or any member of the staff responsible for any errors or omission that I may have made in the completion of this form.

Please print patient's name

Patient's (or legal guardian's) Signature Today's Date

Statement of Office Policies

(August 21, 2012)

By signing this, I agree to the financial responsibilities and office policies established on the Statement of Office Policies page.

Patient's (or legal guardian's) Signature Today's Date

Notice of Privacy Practices

(HIPPA)

(March 03, 2011)

By signing this, I agree that I have read and agree with the policies established on the Notice of Privacy Practices pages.

Patient's (or legal guardian's) Signature Today's Date

Copies of the above forms can be obtained upon request for your own personal records.

Family Dental Care, PC
Dr. Nicole Stachewicz Johnson, D.M.D.
Dr. Robert C. Anderson, D.M.D.
4206 East Lake Road
Erie, PA 16511

Notice of Privacy Practices

(Updated: March 03, 2011)

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 the Notice while it is in effect. This Notice takes effect **06/15/09** and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the 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 the 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 the notice, pleases contact us using the information listed at the end of this Notice.

By signing this form, you will consent to our 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.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us an 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 of 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, by written consent.

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 of 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 x-rays, written prescriptions, 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 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 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 practically 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. Copies may be requested without charge. If you prefer, we will prepare a summary or 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 six years, but not before April 14th, 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 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 if you 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.

Contact Officer: **Nicole Stachewicz Johnson, D.M.D.**
Telephone: **(814) 899-0602** Fax: **(814) 898-0990**
E-mail: **nicolesjohnson@fdcoferie.com**
Address: **4206 East Lake Road**
Erie PA 16511

Family Dental Care, PC

Nicole Stachewicz Johnson, D.M.D.
Robert C. Anderson, D.M.D.
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Statement of Office Policies – Financial Responsibilities

(Updated: August 21, 2012)

Before any work is completed, the doctor will do a thorough examination of your mouth in the case of an emergency she/he will do a limited evaluation of the particular problem area. Then after explaining various treatment options along with cost, a course of treatment shall be determined. **Please note** that some teeth may have hidden decay that could potentially require more extensive dental treatment during procedures that would result in an additional cost that were not previously quoted in the original treatment plan.

Payment options are **cash, check, credit card and Care Credit. If you have insurance,** we will submit a claim for you. You are responsible, at the time of your appointment, for any deductible or co-pay not covered by insurance company. We will estimate your portion so that you will be prepared to pay at the time services are rendered. This is based on the information your insurance company has provided us. Once our office has received payment from your insurance company, you will be billed for any additional amount still due, as you are responsible for any charges that exceed your benefits. If in the event you or your insurance pays more than estimated, a credit will be applied to your account towards your next visit or a check will be issued to you.

Insurance Patients: Please Read Carefully

Your insurance is a contract between you, your employer and your insurance carrier. We are not a party of that contract. Our professional services are rendered to you, NOT the insurance company. Please be advised that although your insurance benefits state that you will have 100%, 80% or 50% coverage, this is based on their fee scheduled which may differ from our fees. Lower payment is a result of the plan your employer has chosen for you. We are required by law to collect any co-payment.

In the event that you would need a filling restoration on a tooth, please understand that it will be **COMPOSIT/RESIN** (white filling) and not **AMALGAM** (silver filling). This is the doctor's professional and personal preference. Although we will request benefits for a composite restoration, some subscribers' dental contracts provide an allowance for an amalgam filling on a posterior tooth. Therefore, an allowance will be made for an amalgam restoration at a lower percent. You will be responsible for any difference between our charge and the allowance your insurance company will pay.

I understand that I am directly and fully financially responsible to Family Dental Care, PC (FDC) for charges not covered by my insurance company. In the event I receive payment from my insurance carrier, I agree to endorse the payment I receive directly over to this office for which these fees are payable. I understand such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover. I realize that if my insurance fails to pay or if there is not payment made within 60 days, it is my responsibility to pay my bill directly.

I further understand and agree that no payment plans are offered by FDC and that my balance is to be paid in full unless specific arrangements have been made with the Office Manager. I also acknowledge that if my balance is not paid in full in a timely fashion, I will be responsible for all costs associated with collection, including filing fees and attorney fees.

There will be a $30.00 charge on all returned checks. If the bank charges us a fee for your returned check you will also be responsible for that charge. There will also be a $25.00 charge for all broken appointments without 24 hour notice prior to the appointment.

Signing DOES NOT obligate the patient to make an appointment.
A copy of these authorizations and agreements shall be as valid as the original and given to the patient upon request.