

BECKETT DENTAL CARE  
Dr. Nicholas Grabarz  
(513)870-0700

PATIENT INFORMATION

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ M / F

PATIENT'S SOCIAL SECURITY # \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_

PARENTS' NAME(S) (IF CHILD) \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
street city state zip

TELEPHONE NUMBER - HOME # \_\_\_\_\_ WORK #(PARENT'S IF CHILD) \_\_\_\_\_

CELL PHONE# \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT \_\_\_\_\_

BILLING ADDRESS (IF DIFFERENT) \_\_\_\_\_  
street city state zip

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE# \_\_\_\_\_

EMPLOYER (PARENT'S, IF CHILD): \_\_\_\_\_

ADDRESS OF EMPLOYER: \_\_\_\_\_

IS PATIENT COVERED BY DENTAL INSURANCE THROUGH THIS EMPLOYER? \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SS# \_\_\_\_\_

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER (CIRCLE ONE)

DENTAL INSURANCE CO. AND ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

GROUP # \_\_\_\_\_

IS PATIENT COVERED BY ANY OTHER DENTAL INSURANCE? \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SS# \_\_\_\_\_

EMPLOYER NAME AND ADDRESS \_\_\_\_\_

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER (CIRCLE ONE)

SECONDARY INSURANCE NAME AND ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

GROUP # \_\_\_\_\_

\*PLEASE KEEP US INFORMED OF ANY CHANGES IN ADDRESS OR INSURANCE COVERAGE.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(PARENT'S IF A MINOR)

WHO (OR WHAT) INFLUENCED YOU TO CHOOSE OUR OFFICE? \_\_\_\_\_

THE HIGHEST COMPLIMENT OUR PATIENTS CAN PAY US IS THE REFERRAL OF THEIR FRIENDS AND RELATIVES. FEEL FREE TO GIVE OUR NAME AND NUMBER TO SOMEONE THAT WE MAY BE OF SERVICE TO. WE ARE ALWAYS HAPPY TO WELCOME NEW PATIENTS INTO OUR PRACTICE!



## Beckett Dental Care

We welcome you to our practice and look forward to a long-lasting partnership with you! Please read the information below which should help you with some of our most commonly asked questions.

### Office Hours

Monday through Thursday 8 AM to 5PM and two Fridays a month 7AM to 3PM

### Emergencies

If you are experiencing a dental emergency such as toothache or broken tooth, please call immediately. We consider emergencies a true priority and will do all we are able to care for your pain. When closed, emergency numbers will be available to reach Dr. Grabarz.

### Broken Appointments and Cancellations

We strive to provide our patients with appointments that accommodate their schedule conveniently. Please know that appointment time is reserved specifically for you. Last minute cancellations and forgotten appointments limit our ability to serve all of our patients in a convenient and timely manner. We, therefore, ask that you provide us with at least 24 hours notice prior to changing your reserved appointment, thus allowing us the opportunity to offer that time to other patients.

### Insurance

As a courtesy to our patients, we file insurance claims on their behalf. However, please know that, with the exception of contracted networks, *Beckett Dental Care is not a part of the employer/employee/insurance company contract.* While we assist patients with claims and strive to utilize benefits to their utmost, benefits are ultimately determined based upon individual contracts and plan administrators. Beckett Dental Care cannot accept responsibility for non-payment from insurance companies. It is imperative that patients have a complete understanding of their dental benefits. Your Human Resources Department can best assist you with the specific details of your plan.

### Financial Arrangements

When full payment is made on the date of service, we offer a 5% discount for cash or check and a 2% for credit card. For your convenience, we accept Visa, MasterCard, American Express and Discover. Payment on account balances may be made via mail, phone and through our online patient portal, SmileDash. Additionally, we are a Care Credit provider and will gladly assist you in obtaining a Care Credit Account. There is a 1.5% finance charge per month (18% annually) on account balances aged over 60 days.

I have read and understand the Policies and Procedures of Beckett Dental Care.

---

Signature

---

Date

ACKNOWLEDGEMENT OF RECEIPT OF

**BECKETT DENTAL CARE NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have been provided with a copy of the Beckett Dental Care Notice of Privacy Practices and I have therefore been advised of how health information about me may be used and disclosed by Beckett Dental Care and how I may obtain access to and control this information.

X \_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN

X \_\_\_\_\_  
PRINT NAME OF PATIENT

X \_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

1. Please list who you want to have access to your pertinent medical information:  
(I.e.: family member, spouse, and significant other)

\_\_\_\_\_

2. May we leave a message on your answering machine? YES NO

3. Preferred method of contact?

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Work # \_\_\_\_\_ Other # \_\_\_\_\_

4. May we leave messages by use of Email? YES NO

Email Address \_\_\_\_\_

Updated: \_\_\_\_\_

\_\_\_\_\_

THIS SECTION WILL BE COMPLETED IF THE WRITTEN ACKNOWLEDGEMENT IS NOT OBTAINED

We have made a good faith effort to obtain an individual's acknowledgement, but the acknowledgement was not obtained for the following reason(s):

\_\_\_The individual refuses to sign or otherwise fails to provide an acknowledgement.

\_\_\_The individual was mailed a copy of the Notice and did not mail back his or her receipt of acknowledgement.

\_\_\_Other \_\_\_\_\_

Completed by: \_\_\_\_\_

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 April 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 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 \$0.00 for each page, \$0.00 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: Office Manager

Telephone: 513-870-0700 Fax: 513-870-0752

E-mail: \_\_\_\_\_

Address: 8300 Princeton-Glendale Road West Chester, OH 45069

---

© 2002 American Dental Association

All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

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