J Friedman Alexandria LLC

113 S Harrison St • Alexandria, IN 46001-2021 (765)724-7777

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ________ Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: ________ Prev. Visit: ________ Email Address: ____________

Phone: ________ ________ ________ ____ Best time to call: ________
Home Mobile Work Ext

Address: ____________ ____________
Address 1 Address 2

____________ ____ ____-____
City State Zip Code

Name of Insured: ____________ ____________ ____
Last First MI

Insured's Birth Date: ________ ID #: ________ Group #: ________

Insured's Address: ____________ ____________
Address 1 Address 2

____________ ____ ____-____
City State Zip Code

Insured's Employer Name: ____________

Employer Address: ____________ ____________
Address 1 Address 2

____________ ____ ____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____________

Insurance Address: ____________ ____________
Address 1 Address 2

____________ ____ ____-____
City State Zip Code

Are you experiencing any of the following dental concerns?

☐ Tooth pain ☐ Cavities ☐ Pain when biting ☐ Hot/cold sensitive ☐ Bleeding gums ☐ Bad breath ☐ Dry mouth

☐ Broken teeth ☐ Food traps ☐ Jaw pain ☐ Wisdom teeth pain

Women, are you currently PREGNANT ◯ Yes ◯ No

☐ A Fib	☐ Acid Reflux	☐ ADHD	☐ Alzheimers
☐ Anemia	☐ Arthritis/Gout	☐ Artificial Joints	☐ Aspirin Allergy
☐ Asthma	☐ Bariatric Surgery	☐ Blood Thinner Med	☐ Bone Growth Stimulat
☐ Cancer	☐ Cephalexin Allergy	☐ Chemotherapy	☐ Cholesterol
☐ Cipro Allergy	☐ Cleocin Allergy	☐ Codeine Allergy	☐ Cold Sore/Fever Blis
☐ Cortisone Medicine	☐ Diabetes	☐ Drug Addiction	☐ Erythromycin Allergy
☐ Excessive Bleeding	☐ Heart Attack w/ 1yr	☐ Heart Disease	☐ Heart Murmur
☐ Heart Stint .	☐ Heart Valve Replaced	☐ Hepatitis	☐ High Blood Pressure
☐ HIV	☐ Hypoglycemia	☐ Jaundice	☐ Kidney Dialysis/Dise
☐ Latex Allergy	☐ Liver Disease	☐ Low Blood Pressure	☐ Morphine Allergy
☐ Narcotics Allergy	☐ NO Epinephrine	☐ Osteoporosis Med Pt	☐ Pacemaker
☐ Parkinsons	☐ Penicillin Allergy	☐ Pregnancy	☐ Pre-Med
☐ Psychiatric Care	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatism
☐ See Notes	☐ Seizures	☐ Sinus Problems	☐ Sleep Apneia
☐ Stroke w/ 1 yr	☐ Stroke	☐ Sulfa Allergy	☐ Tetracycline Allergy
☐ Thyroid Disease	☐ Tumors	☐ Tylenol Allergy	☐ Ulcers

List Any Drug Allergies

____

____

Please list all medications that you are currently taking on a regular basis including any dietary supplements.

____

____

____

____

Have you ever been told to take an antibiotic pre-medication before dental visits before? ◯ Yes ◯ No

Have you ever had any artificial joints or artificial heart valves placed? ◯ Yes ◯ No

Have EVER had any surgical procedures. Please list ALL procedures below * ◯ Yes ◯ No

If yes, please list below

____

____

____

Name and Phone of Family Physician ____________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the Doctor at the next appointment without fail.

Patient/Guardian

Signature ______________________________ Date ____________

Dr. Jeremy Friedman

Alexandria Family Dental

Response Date: ___/___/_______

J Friedman Alexandria LLC

113 S Harrison St • Alexandria, IN 46001-2021 (765)724-7777

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________ ______________________ ___ ______________________

Last First MI Preferred Name

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 4/14/03 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, 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 anytime. 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 may charge you for copies and 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.

J Friedman Alexandria LLC
Address: 113 S Harrison Street, PO Box 177, Alexandria, IN 46001
Telephone: (765) 724-7777 Fax: (765) 724-2141
E-mail: Alexandriafd@att.net

© 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).

I authorize Alexandria Family Dental to discuss my account and appointment information with the following individuals.

____

____

____

____

☐ **I understand that I may obtain a copy of the office's Notice of Privacy Practices at any time**

Signature of patient, parent, or guardian (responsible party):

Signature ______________________________ Date __________

Response Date: ____/____/______

J Friedman Alexandria LLC

113 S Harrison St • Alexandria, IN 46001-2021 (765)724-7777

Appointment Guidelines

Please review this sheet as it contains information concerning your upcoming dental visits.

After dental visits, we typically reserve our patients' next appointment. This ensures patients receive the important dental care they need. It also provides greater flexibility to select an appointment time that works well for their schedule.
As a courtesy, we strive to contact all scheduled patients by phone, 24 to 48 prior to their dental visit. Please make sure we have documented your current work, home and cell numbers.
Our office is committed to providing excellence in patient service and care. Therefore, we invest a great deal of time each day coordinating schedules, contacting patients and confirming appointments.

We have an important favor to ask.

As you receive your appointment courtesy reminder phone call, please check your personal calendar to ensure you have documented this appointment. If you find there is a scheduling conflict, please contact our office immediately at (765)724-7777 and we will gladly assist you in rescheduling your dental visit. If possible, please do not wait until we contact you just prior to your appointment to request a scheduling change. Short-notice appointment cancellations are very disruptive to our patient flow and daily schedule, making them very difficult to accomodate.

We ask that our patients provide a minimum of 24 hours advance notice, when requesting a scheduling change. When patients provide advance notification, we are able to arrange care for other patients who are experiencing urgent dental needs.

Please be advised, patients who cancel an appointment with less than 24 hours notice, or fail to arrive for their scheduled appointment, may be assessed a cancellation fee of $52.00. We will allow one short-notice cancellation before assessing this fee. Any fees assessed will not be submitted to dental insurance carriers and are to be paid in-full before any additional dental visits can be scheduled. If a patient has three or more short-notice cancellations and /or failed appointments, they must prepay for their next dental visit in-full at the time the appointment is scheduled. The non-refundable appointment deposit will be applied to the dental services planned. If the patient cancels their appointment with less than two business days advance notice, or fails to arrive, their deposit will not be refunded.

We appreciate your understanding and assistance in fulfilling our goal of schedule coordination for our valued patients. Your signature below indicates you have reviewed this informaiton and agree to assist us in this effort. If you have any questions, please feel free to contact our office at (765)724-7777.

Signature ____ **Date** __________

Response Date: ____/____/_______

COVID-19 Dental Treatment Consent Form

I, ______________________________, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. ____________ (initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of breath
- Dry Cough
- Runny Nose
- Sore Throat

__________ (initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has traveled and this is no possible with dentistry ___________ (initial)

- I verify that I have not **traveled outside the United States** in the past 14 days to countries that have been affected by COVID-19. ____________ (initial)
- I verify that I have **not traveled domestically** within the United States by commercial airline, bus, or train within the past 14 days. ____________ (initial)

Date: ____________________

Signature: ______________________________