DENTISTRY 23

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Patient's Name_____ **Name Preferred**_____ **Today's Date**_____
Sex: M __F__Birthdate_____Age:_____SSN:_____
Please check one: Single__ Married__ Separated__ Widow__ Occupation:_____
Home Address:_____City:_____State:_____Zip:_____
E-Mail Address:_____
Home Phone #:_____Work Phone #:_____
Cell Phone #:_____Fax #:_____
Are any other family members currently patients?_____If yes please list:_____
Your Employer:_____How Long Employed:_____
Are you a fulltime student?_____If patient is a minor: Mother's DOB:_____Father's DOB:_____

Person responsible for Account:_____SSN:_____
Address:_____
Home Phone #:_____Work Phone #:_____
Cell Phone #:_____Fax #:_____
Employer:_____

EMERGENCY INFORMATION
Name, Address & Phone # of relative not living with you:_____
_____

How did you hear about our office? Yellow pages Newspaper School Work Other_____
Name of person or other patient who referred you_____

Dental Insurance Information (Primary Carrier)

Insured's Name:_____
DOB:_____SSN:_____
Insured's Employer:_____
Insurance Company:_____
Ins Co Address:_____
_____
Phone #:_____
Group #:_____Local #:_____

If you have two insurance coverage's, complete this for the second coverage

Insured's Name:_____
DOB:_____SSN:_____
Insured's Employer:_____
Insurance Company:_____
Ins Co Address:_____
_____
Phone #:_____
Group #:_____Local #:_____

DO YOU NEED TO PRE-MEDICATE FOR ANY REASON? Y N
EXAMPLE: FOR ARTIFICIAL JOINT, ARTIFICIAL HEART VALVE OR MURMUR
APPROX. DATE OF LAST DENTAL EXAM: _____**LAST XRAYS:**_____

Medical History

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name: _____ **Phone:** _____ **Date of last medical exam:** _____

What was the exam for? _____ **Current Physician:** _____

	Y	N
Have you ever been hospitalized or had a major operation?	☐	☐
Are you under the care of a physician?	☐	☐
Have you ever had a serious head or neck injury?	☐	☐
Are you taking any medications or supplements?	☐	☐

If yes please list, the dose and how often: _____

(use back of paper if needed) _____

	Y	N
Do you take or have you taken Phen-Fen or Redux?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐
Are you on a special diet?	☐	☐
Do you use Tobacco?	☐	☐
Do you use controlled substances?	☐	☐

Women

	Y	N
Are you pregnant or trying to get pregnant?	☐	☐
Are you taking contraceptives?	☐	☐
Are you nursing?	☐	☐

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Local Anesthetics
- ☐ Acrylic
- ☐ Codeine
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Other

CHECK ALL THAT APPLY: **FAMILY HISTORY UNKNOWN?** ☐ YES ☐ NO

	HAVE	HAD	FAMILY HISTORY
Acid Reflux	☐	☐	☐
AIDS\HIV Positive	☐	☐	☐
Alzheimer's Disease	☐	☐	☐
Anaphylaxis	☐	☐	☐
Anemia	☐	☐	☐
Angina	☐	☐	☐
Arthritis\Gout	☐	☐	☐
Artificial Heart Valve	☐	☐	☐
Artificial Joint:	☐	☐	☐
What Joint? _____			
When? _____			
Asthma	☐	☐	☐
Blood Disease	☐	☐	☐
Blood Transfusion	☐	☐	☐
Breathing Problem	☐	☐	☐
Bruise Easily	☐	☐	☐
Cancer	☐	☐	☐
Type? _____			
Chemotherapy	☐	☐	☐
When? _____			
Chest Pains	☐	☐	☐
Cold Sores\Fever Blisters	☐	☐	☐
Congenital Heart Disorder	☐	☐	☐
Convulsions	☐	☐	☐
Cortisone Medicine	☐	☐	☐
Diabetes	☐	☐	☐
Drug Addiction	☐	☐	☐
Dry Mouth	☐	☐	☐
Easily Winded	☐	☐	☐
Emphysema	☐	☐	☐

	HAVE	HAD	FAMILY HISTORY
Epilepsy\Seizures	☐	☐	☐
Excessive Bleeding	☐	☐	☐
Excessive Thirst	☐	☐	☐
Fainting Spells\Dizziness	☐	☐	☐
Frequent Cough	☐	☐	☐
Frequent Diarrhea	☐	☐	☐
Frequent Headaches	☐	☐	☐
Genital Herpes	☐	☐	☐
Glaucoma	☐	☐	☐
Hay Fever	☐	☐	☐
Heart Attack\Failure	☐	☐	☐
Heart Murmur	☐	☐	☐
Heart Pace Maker	☐	☐	☐
Heart Trouble\Disease	☐	☐	☐
Hemophilia	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B or C	☐	☐	☐
Herpes	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Hives or Rash	☐	☐	☐
Hypoglycemia	☐	☐	☐
Inflammatory disease	☐	☐	☐
Type? _____			
Irregular Heartbeat	☐	☐	☐
Kidney Problems	☐	☐	☐
Leukemia	☐	☐	☐
Liver Disease	☐	☐	☐
Low Blood Pressure	☐	☐	☐
Lung Disease	☐	☐	☐

	HAVE	HAD	FAMILY HISTORY
Mitral Value Prolapse	☐	☐	☐
Osteoporosis	☐	☐	☐
Pain in Jaw Joints	☐	☐	☐
Parathyroid Disease	☐	☐	☐
Psychiatric Care	☐	☐	☐
Radiation Treatments	☐	☐	☐
When? _____			
Recent Weight Loss	☐	☐	☐
Renal Dialysis	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatism	☐	☐	☐
Scarlet Fever	☐	☐	☐
Shingles	☐	☐	☐
Sickle Cell Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sleep Apnea	☐	☐	☐
Did you wear a c-pap?	Y ☐		N ☐
Spina Bifida	☐	☐	☐
Stomach\Intestinal Disease	☐	☐	☐
Stroke	☐	☐	☐
Swelling of Limbs	☐	☐	☐
Thyroid Disease	☐	☐	☐
Tonsillitis	☐	☐	☐
Tuberculosis	☐	☐	☐
Tumors or Growths	☐	☐	☐
Ulcers	☐	☐	☐
Venereal Disease	☐	☐	☐
Yellow Jaundice	☐	☐	☐

HAVE EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ YES ☐ NO

If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ **Date:** _____

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist of **23 Dentistry** and/or dental auxiliaries of his choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
    - Preventive hygiene treatment (prophylaxis) and the application of topical fluoride
    - Application of plastic "sealants" to the grooves of the teeth
    - Treatment of diseased or injured teeth with dental restorations (fillings and crowns)
    - Replacements of missing teeth with dental prostheses (bridges, partial dentures, full dentures)
    - Removal (extraction) of one or more teeth
    - Treatment of diseased or injured oral tissues (hard and/or soft)
    - Use of sedative drugs to control apprehension and/or disruptive behavior
    - Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
    - Use of general anesthesia to accomplish the necessary treatment
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart infection) and lack or oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I authorize the doctor to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific.
7. I will be advised that the success of dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.
10. I acknowledge that a copy of the Health Insurance Portability & Accountability Act of 1996 was made available to me.

Patient's Name _____ Date: _____

Name of Parent or Guardian: _____ Relationship to Patient _____

Signature of Patient,Parent, or Guardian: _____

Witness: _____

Financial Agreement
(Please check A or B as applicable and sign below)

A With Dental Insurance- please read and check the following option

If you have dental insurance we will gladly file it for you. We request that you pay your patient portion today, on the day of treatment, which is the estimated amount your insurance will not cover. We will verify your benefits and inform you of this amount on the day of your appointment for you. Once insurance pays, we will send you a statement or refund as needed to reconcile your account.

_____ I have insurance and will pay my estimated patient portion by cash, check, credit card, or post dated check today.

B Without Dental Insurance- please read and check one of the following options

I do not have dental insurance and will pay by:

_____ **Cash, credit card, or check payment** in full on the day of treatment.
_____ **Care Credit** 12 or 18 months interest free for treatment totaling $200 or more. Please ask for more information to apply with CareCredit if you are interested.
_____**Pre-payment discount** for treatment plans over $300 if paid in full prior to appointment date, 5% for any pre-payment. We accept Visa, Mastercard, and Discover.

Assignment of Benefits for Insurance Checks

I hereby instruct and direct my insurance carrier to pay by check made out and mailed to Beadle 23 Dentistry. For the dental expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Beadle 23 Dentistry to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I have read and understand the above. I agree to the payment option I have selected and agree to pay any and all collection, attorney fees, court cost, interest fees (5% per month after 90 days) and/or any other additional fees should my account be turned over to any attorney, Collection Service Agency or Transworld. I understand I am paying an estimated amount and I am responsible for any remaining balance after insurance pays. I realize that I am also responsible for a $20 service charge for any returned check.

Cancellation Policy

I understand I may be subject to a broken appointment fee of $25 if I fail or cancel my appointment with less than 24 hours notice.

_____ _____
Patient / Responsible Party Signature Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 3, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

23 Dentistry

Ralph Beadle, DMD

16005 US 23 South

Catlettsburg, KY 41129

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: (877) 696-6775