



You're new to our practice (welcome!). Before we get started on your treatment plan, we'd like to share with you our approach to service.

Preventive dentistry is our goal for every patient. It involves the daily care, good nutrition, and periodic check-ups and cleanings that maintain good dental health already achieved. Preventive dentistry may not be where we start with every patient, but it's where we like to finish.

Restorative dentistry is basic repair of the mouth. We mend broken or leaking fillings, build crowns and bridges, fit partial and full dentures, and realign your bite. Where necessary, gum disease is treated, or root canal therapy recommended. The prevailing belief behind restorative dentistry is a simple one: you can keep all your teeth for all your life.

Cosmetic dentistry, which includes bleaching of the teeth, is coming of age with new materials and procedures that make a beautiful smile accessible to everyone. Because our preventive and restorative programs have been so successful, we now have the luxury of considering cosmetic treatment for spaces, chips, and otherwise less-than-perfect smiles.

When we welcome a new patient to the practice, we also welcome any questions he/she may have about office policies, insurance, and of course, fees. We work extremely hard to control the cost of dental care. It's part of our philosophy that quality care should be available to everyone.

Insurance makes life easier. We will try to help answer any questions you may have about your coverage. Each policy is different, but in general, insurance usually covers about 80% – 100% of simple care (cleanings, x-rays, periodic exams, etc.) and 50% of major work (crowns, root canals, etc.). Preauthorization for major work will tell you the amount of your obligation ahead of time (no one likes these kinds of surprises).

We will file your claim electronically as a courtesy to you. We ask that you pay your estimated portion of services on the day they are completed. Any charges not covered by your insurance company are your responsibility (we do accept VISA and Mastercard). If you do not have insurance coverage, we can work out alternative financial arrangements that suit us both. The way we see it, there is always a way to get the help you need.

Please complete the enclosed registration forms and bring them with you to your appointment scheduled on

Please let us know if you have any questions. Again, welcome. We all look forward to meeting you!

Patient Registration



Patient First Name: _____ Last Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

Patient Information

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Primary Dental Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other

Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Secondary Dental Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other

Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Medical History



Patient Name: _____

Although dental personnel primarily treat the area in and 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.

- Are you under a physician's care now? ___ Yes ___ No ___ N/A _____
- Have you ever been hospitalized or had a major operation? ___ Yes ___ No ___ N/A _____
- Have you ever had a serious head or neck injury? ___ Yes ___ No ___ N/A _____
- Are you taking any medications, pills, or drugs? ___ Yes ___ No ___ N/A _____
- Do you take, or have you taken, Phen-Fen or Redux? ___ Yes ___ No ___ N/A _____
- Do you use tobacco? ___ Yes ___ No ___ N/A _____
- Are you on a special diet? ___ Yes ___ No ___ N/A _____
- Do you use controlled substances? ___ Yes ___ No ___ N/A _____
- Women: Are you ___ Pregnant ___ Trying to get pregnant? ___ Nursing? ___ Taking oral contraceptives? _____

Are you allergic to any of the following?

- ___ Aspirin ___ Penicillin ___ Codeine ___ Acrylic ___ Metal ___ Latex ___ Local Anesthetics ___ Other

Do you have, or have you had, any of the following?

- | | | | | |
|-----------------------------|-------------------------------|---------------------------|----------------------------|--------------------------------|
| ___ AIDS/HIV Positive | ___ Chest Pains | ___ Frequent Headaches | ___ Irregular Heartbeat | ___ Scarlet Fever |
| ___ Alzheimer's Disease | ___ Cold Sores/Fever Blisters | ___ Genital Herpes | ___ Kidney Problems | ___ Shingles |
| ___ Anaphytaxis | ___ Congenital Heart Disorder | ___ Glaucoma | ___ Leukemia | ___ Sickle Cell Disease |
| ___ Anemia | ___ Convulsions | ___ Hay Fever | ___ Liver Disease | ___ Sinus Trouble |
| ___ Angina | ___ Coilisone Medicine | ___ Heart Attack/Failure | ___ Low Blood Pressure | ___ Spina Bifida |
| ___ Arthritis/Gout | ___ Diabetes | ___ Heart Murmur* | ___ Lung Disease | ___ Stomach/Intestinal Disease |
| ___ Artificial Heart Valve* | ___ Drug Addiction | ___ Heart Pace Maker* | ___ Mitral Valve Prolapse* | ___ Stroke |
| ___ Artificial Joint* | ___ Easily Winded | ___ Heart Trouble/Disease | ___ Pain in Jaw Joints | ___ Swelling of Limbs |
| ___ Asthma | ___ Emphysema | ___ Hemophilia | ___ Parathyroid Disease | ___ Thyroid Disease |
| ___ Blood Disease | ___ Epilepsy or Seizures | ___ Hepatitis A | ___ Psychiatric Care | ___ Tonsillitis |
| ___ Blood Transfusion | ___ Excessive Bleeding | ___ Hepatitis B or C | ___ Radiation Treatments | ___ Tuberculosis |
| ___ Breathing Problem | ___ Excessive Thirst | ___ Herpes | ___ Recent Weight Loss | ___ Tumors or Growths |
| ___ Bruise Easily | ___ Fainting Spells/Dizziness | ___ High Blood Pressure | ___ Renal Dialysis | ___ Ulcers |
| ___ Cancer | ___ Frequent Cough | ___ Hives or Rash | ___ Rheumatic Fever* | ___ Venereal Disease |
| ___ Chemotherapy | ___ Frequent Diarrhea | ___ Hypoglycemia | ___ Rheumatism | ___ Yellow Jaundice |

Have you ever had any serious illness not listed above? ___ Yes ___ No ___ N/A _____

Comments: _____

*Condition may require medication N/A - Not answered by patient

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: _____

Dental History



What is the purpose of today's visit? _____

How long since your last visit? _____

What treatment did you receive? _____

Previous Dentist's Name: _____

Address: _____ Phone: _____

How long since you have had your teeth cleaned? _____

Please circle Yes or No for the following questions:

Have you made regular visits? Yes No

How often? _____

Were dental radiographs taken? Yes No

Have you ever lost teeth or had them removed? Yes No

Why? _____

Have they been replaced? Yes No

If so, how were they replaced?

Fixed Bridge _____ Age _____

Removable Partial _____ Age _____

Full Denture _____ Age _____

Implant Therapy _____ Age _____

Are you unhappy with the replacement? Yes No

If yes, please explain: _____

Would you like to discuss replacement options? Yes No

Do you clench or grind your teeth? Yes No

Does your jaw click or pop? Yes No

Have you experienced pain or soreness in the muscles of your face or around your ear? Yes No

Do you have frequent headaches, neck pain or shoulder aches? Yes No

Does food ever get caught between your teeth? Yes No

Are any of your teeth sensitive to: ___Hot? ___Cold? ___Sweets? ___Pressure? ___Biting?

Do your gums bleed or hurt? Yes No

If yes, when? _____

How often do you brush? _____ Floss? _____

Do you have any loose, broken, or shifted teeth? Yes No

Are you unhappy with the appearance of your teeth? Yes No

Is there anything you would like to change about your teeth? Yes No

Have you ever had gum treatment or surgery? Yes No

If yes, when? _____ what was done? _____

Have you ever had orthodontics (braces)? Yes No

Have you ever had any complications following dental treatment? Yes No

If so, explain: _____

Do you have anything about dentistry that you strongly dislike or have any unpleasant experiences or concerns?

Patient/Guardian Signature: _____



Financial Policy

All of us at Beavers Caring Family Dentistry are happy to have you as a patient, and we are excited about the future of our practice. We are committed to providing you with the highest quality dental care using only the best materials and technology available in the market today. We have invested a great deal of time and effort to update our software system to better serve our patients.

1. We accept cash, check, VISA, and Mastercard as payment. Payment is due at the time of service for all emergency care, nitrous oxide, and cosmetic procedures.
2. Insurance makes our life easier. If you have dental insurance, we expect you to pay your estimated share of the total fee at your visit. We will then file your insurance as a courtesy to you. Dental insurance rarely pays all the charges, and you are always responsible for the full fee. The fees charged for services rendered are the usual and customary fees charged to all of our patients for similar services. Be aware that insurance coverage varies greatly between policies, and your policy may base its allowance on a fee schedule that may not coincide with our fees. You must provide us with the necessary names, addresses, and identification numbers along with proof of insurance eligibility if you would like us to bill your insurance company for you. If your insurance company does not remit payment within 60 days, the unpaid balance will be due from you. We may add a billing fee to all accounts 60 days past due.
3. We are always willing to set up additional financial arrangements for our patients with treatment plans. These arrangements must be made with a financial coordinator prior to scheduling your treatment.

We value you as a patient of our practice. We hope that by informing you of our policies we can avoid any misunderstandings. If you have any questions about any of the financial options available, please feel free to discuss them with our dedicated staff members.

Sincerely,
Dr. Wayne

Patient/Guardian Signature _____ Date _____



HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party. For example, your protected health information may be provided to a specialist to whom you have been referred to ensure that the specialist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a restoration may require that your relevant protected health information be disclosed to the dental plan to obtain approval for the restoration.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to dental students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without authorization. These situations include: as Required by Law, Public Health issues are required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors: and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complainto us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

How would you prefer to be contacted: At home At work By cell phone

Can we leave a message on your: Answering Machine Yes No Voice Mail Yes No

Designated relatives and friends:

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number (467-0654).

Signature below is only as acknowledgement that you have received this Notice of our Privacy Practices:

Print Name _____ Signature _____ Date _____