BEACH VIEW FAMILY DENTAL

Simply Sensational Smiles

Dr. Karen M. Crews *Dr. Megan Blackman*

WELCOME TO OUR OFFICE!

PATIENT INFORMATION (Confidential) Date: _____

Name: _____ How do you prefer to be addressed? _____

Birthdate: _____ Age: _____ SS# _____

Physical Address: _____ Home Ph# _____

City_____State _____ Zip _____ Sex: M F

Work Ph# _____ Cell Ph# _____ Best phone # to reach me on: _____

Email address: _____ Single Married Widow Separated Divorced

Occupation: _____ Employer: _____

If student, name of School/College: _____ PT Full

Whom may we thank for referring you to our office: _____Phone #: _____

Contact in case of an emergency: _____ Phone #_____

If the person responsible for this patients' account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information."

Name of responsible party: _____Relationship to Patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home ph# _____ Work ph# _____ Cell Ph# _____

Occupation: _____ Employer: _____

Sex: M F Birthdate: _____ Age: _____ SS#_____

Dental Insurance Information

Insurance Name: _____ Group #: _____

Subscriber Name: _____ Relationship to Patient: _____

DOB: _____ SS#/ID#_____ Employer: _____

Consent for Services

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, the dental office cannot render services on the assumption that our charges will be paid by an insurance company.

_____ _____

Signature of patient, parent or guardian Date

Payment is expected at each appointment. For your convenience, we offer the following methods of payment:

__Cash ___ Discover ___Visa/MasterCard ___Care Credit _____Amer Exp _____Debit Card

(Over)

Health Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

YES	NO		
☐	☐	1.	Are you under medical treatment now?
☐	☐	2.	Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____
☐	☐	3.	Are you taking any medications(s) including non -prescription medicine? If yes, what medication(s) are you taking? _____
☐	☐	4.	Have you ever taken Fen-Phen/Redux?
☐	☐	5.	Do you use tobacco?
☐	☐	6.	Do you use controlled substances?
☐	☐	7.	Are you wearing contact lenses?
☐	☐	8.	Have you ever been told you snore?
☐	☐	9.	Do you have excessive daytime sleepiness?
☐	☐	10.	Do you have sleeplessness?

11. Are you allergic to or have you had any reactions to the following?

	YES	NO
Local Anesthetic (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
Any food allergies	☐	☐

If so, please list food allergies _____

12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3weeks)? ☐ ☐

13. Women only:

a) Are you pregnant or think you may be pregnant? ☐ ☐

b) Are you nursing? ☐ ☐

Do you have or have you had any of the following:

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies
☐	☐	Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or	☐	☐	Heart Trouble
☐	☐	Kidney Diseases	☐	☐	Implant	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Hepatitis/Jaundice	☐	☐	Mitral Valve Prolapse
☐	☐	Thyroid Problem	☐	☐	Sexually Transmitted	☐	☐	

Authorization and Release

I certify that I understand and have answered the above questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of patient (or, if minor, parent/guardian)

Medical History Update—If this is an update of a previous Medical History Form—please complete the following:

Are there any changes to your medical history? YES or NO If yes, please briefly describe the changes:

Date	List changes	Signature of patient (or guardian)	Reviewed by
Date	List changes	Signature of patient (or guardian)	Reviewed by

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NOTICE OF PRIVACY/CONSENT FORM

I, _____, understand that under the Heath Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. I understand that my medical records including x-rays, may be sent via unprotected or unencrypted email or mail. Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that if I have a concern about the privacy of my medical records, I can contact the Beach View Dental Office Manager at (228)896-1840 or concerns can be submitted directly to the United States Department of Health and Human Services.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I give the staff of Beach View Dental permission to contact me by the following methods:

___ Call me including leaving a message on my voice mail or answering machine.
___ Send emails
___ Send texts
___ Send post cards

Signature: _____ Date: _____

Print Name: _____ Relationship to patient: _____

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Payment and Collection Policy

The following financial policies have been enacted to enable us to continue to provide the highest quality dental care to our patients. We value our relationship with our patients and will be happy to assist you regarding our policies and charges.

- We accept payment in the form of cash, checks, Debit Card, Visa, Master Card, Discover and American Express or one of our financial partners.
- If you do not have dental insurance, full payment is required at the time of service.
- If you have dental insurance, we will file your primary insurance as a courtesy to our patients. We can also file secondary insurance, but because of the unpredictability of secondary insurance, we will not be able to estimate secondary insurance benefits.
- We will work with your insurance company to estimate primary benefits. Insurance companies' allowable schedules are set arbitrarily and will never be at 100% of a clinic's fee. Most of the time your insurance coverage is negotiated between your insurance company and employer.
- **You will be responsible for your estimated fees and deductible at the time of service,** as well as any balance that may remain after your insurance payments are received.
- If your insurance company has not paid your account within 90 days, **you are responsible for the balance of your account.**
- **A $40.00 fee will be applied for all NSF/returned/stopped payment checks.**
- If your account is referred to a collection agency, you will be responsible for all fees incurred. There is a 35% processing fee.
- **A charge of $25.00 will be applied for broken/missed appointments** _____ unless 48hr notice is given to our office. If you habitually miss or cancel same day, you may not be offered to reschedule.
- If you are **15mins or later** for your appointment, you will need to reschedule to a more convenient time.
- There will be a **$2 billing fee applied monthly to all unpaid balances.**
- All accounts over 60 days will be charged an APR of 18%.

Please feel free to ask any questions you may have regarding our insurance or payment policies. We will help you in any way we can regarding the processing of your insurance claims.

Please sign below stating that you understand and accept our payment policy.

_____ _____

Patient or Parental Guardian Signature *Date*

9072 Lorraine Road Gulfport, Mississippi 39503 (228)896-1840

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