BEACH VIEW FAMILY DENTAL

228-896-1840

Karen Crews, DMD

Patient Information

Patient Name: _____ Date of Birth: _____
(First) (MI) (Last)

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

Social Security #: _____ Please select one: ☐ Male ☐ Female Age: _____

Patient Employer/School: _____ Occupation: _____ Email: _____

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Best time to reach you is: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name: _____ Relationship: _____

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Please Select One: ☐ Married ☐ Divorced ☐ Single ☐ Minor ☐ Widowed

Spouse Name: _____ Spouse DOB: _____
(First) (MI) (Last)

Spouse Social Security #: _____ Spouse Employer: _____

IF NO SPOUSE:

Beneficiary Name: _____ Relationship: _____

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

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

How did you hear about us? _____

If referred, who may we thank for referring you? _____

Dental Insurance

Insurance Company: _____ Group # _____

Who is responsible for this account? _____ Union or Local # _____

Subscriber's Name: _____ Date of Birth: _____

Social Security #: _____ Relationship to patient: _____

Employer: _____ Work #: (_____) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit: _____

Is this patient covered by additional insurance? ☐ Yes ☐ No (If yes, please add the additional information below.)

Insurance Company: _____ Group # _____

Who is responsible for this account? _____ Union or Local # _____

Employer: _____ Work #: (_____) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit: _____

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Dental History

Reason for today's visit: _____ Date of last dental visit? _____

Former Dentist: _____ Phone: (_____)_____ Date of last dental X-ray? _____

Check if you have or have had a problem with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Sores or growths in your mouth
- ☐ Clicking or poppping jaw
- ☐ Food collecting between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity to cold or hot
- ☐ Sensitivity to sweets

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name: _____ Date of last visit? _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (defenfluramine). ☐ Yes ☐ No

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes, explain: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: _____

(Women only) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Check if you have or have had problems with any of the following: (Please check all that apply.)

- ☐ Anemia
- ☐ Arthiritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough Up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Veneral Disease

List of medications you are currently taking: _____

_____

Allergies:

- ☐ Aspirin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Codeine
- ☐ Iodine
- ☐ Sulfa
- ☐ Barbiurates (Sleeping Pills)
- ☐ Penicillin
- ☐ None

Other _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

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NOTICE OF PRIVACY/CONSENT FORM

I, _____, understand that under the Health 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 amount 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 payments 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 Beach View Family Dental 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 Family Dental permission to contact me by the following methods:

_____ Call me, including leaving a message on my voicemail or answering machine.

_____Send emails.

_____Send texts.

_____ Send post cards.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

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Financial Policy

Thank you for choosing **Beach View Family Dental** as your health care provider. We are committed to offering you quality dental care by an exceptional team of staff and doctors. Please understand that the payment of your bill is considered part of your treatment, and we expect full payment at the time of service. We are in network with Medicaid and most other insurance companies. We accept cash, checks, MasterCard, Visa, and Care Credit. Patients under the age of 18 must have an adult (guardian) above the age of 21 accompany them, and the guardian is responsible for the full payment. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements have been made to make payments.

Each of the following is a statement of our financial policy, which is **required to be read, initialed and signed prior to any treatment.** Please initial below in agreeance to the following statements before signing:

_____ I assume full responsibility for the bill incurred.

_____ I understand that payment is due at the time services are rendered.

_____ I understand that dentistry is not an exact science and success cannot be guaranteed.

_____ I understand that in the event of a returned check, a $35.00 insufficient funds fee will be assessed to my account.

_____ I understand that if my account becomes 30 days past due, it will be subject to a 1.5% interest charge to my account.

_____ I understand that if I do not make a payment toward my account within 90 days, I will be sent to collections and accrue a collections fee totaling up to 50% of the remaining balance on the account at the time of default.

_____ I understand that if this account goes into default, I will be responsible for all court costs, attorney's fees, and any other associated fees.

I, _____, authorize **Beach View Family Dental** and affiliated associates and employees to perform any procedures deemed necessary during my treatment.

I have read the above financial policy. I understand and agree to the terms stated above.

X_____
Signature of Patient or Responsbile Party

Today's Date: _____

X_____
Name Printed of Patient or Responsible Party

All appointments must be canceled 24 hours before the scheduled appointment or a $25.00 no show fee will be added to the patient's account.

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Insurance Policy

Financial Responsibility

I understand that I am financially responsible to **Beach View Family Dental** for any charges not covered by my insurance. Estimates are not a guarantee of payment as exact benefits cannot be determined until claims are filed. I am responsible for the entire bill or balance as determined by **Beach View Family Dental**, if submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all products and services provided.

Each of the following is a statement of our insurance policy, which is **required to be read, initialed and signed prior to any treatment.** Please initial below in agreeance to the following statements before signing:

I acknowledge that it is my responsibility to:

_____Provide an accurate and up-to-date dental/medical insurance information
_____Pay within 30 days on account for any amount due
_____Know that any balance left unpaid for 90 days or longer will be sent to an outside collection agency and will accrue a fee up to 50% of the unpaid balance.

In certain circumstances, insurance companies may send payment directly to the patient. In such cases, the patient agrees to endorse and send the check to Beach View Family Dental . If the patient deposits the check refunded from the insurance company into a personal account, the patient agrees to send a personal check for the equivalent amount to Beach View Family Dental within 10 days of the deposit.

_____ Patient Initials

Assignment of Benefits

I hereby assign all dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance, and any other health/medical plan, to issue payment directly to **Beach View Family Dental**.

Authorization to Release Information

I hereby authorize **Beach View Family Dental** to: (1) release any information necessary to the insurance carrier regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature and this form to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

Name of responsible party (print): _____

Signature of responsbile party: _____

Relationship to insured: _____ Date: _____

This will serve as the responsbile party's signature on file for the purpose of administering insurance benefits.

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How Do You Like Your Smile?

Patient's Name: _____ Preferred Name: _____

Patient's SS #: _____ Date: _____

Chief Concern: _____

Date of last Dental Visit: _____ Last Dental Cleaning: _____ Last Dentist's Name: _____

Do you have any areas in your mouth that concern you now? _____

_____

~~Are~~ your teeth sensitive to:

_____ Hot _____ Cold

_____ Sweets _____ Pressure

Have you ever had:

_____ Orthodontic Treatment

_____ Oral Surgery

_____ Peridontal Treatment

_____ Your Bite Adjusted

_____ Worn A Bite Plate

Have you noticed:

_____ Loosening of your teeth

_____ Food catching between

_____ Pain/Swelling of gums

_____ Bleeding gums

_____ Bad breath

_____ Sore Areas

Have you ever heard of Periodontal Disease (Gum Disease)? Yes or No

Have you ever been examined for it? Yes or No

Have you experience:

_____ Jaw Clicking

_____Pain

_____ Difficulty Opening/Closing

_____ Difficulty Chewing

Have you ever been told that you:

_____ Clench/Grind Teeth

_____ Bite lips/cheeks

_____ Hold foreign objects with your teeth

_____ Breath through your mouth (awake or asleep)

What is most important to you in a dentist? _____

What do you expect from our office? _____

What did you like best about your previous dentist? _____

What did you like least? _____

How long do you expect to keep your teeth? _____

Are you looking to "just need to get by" with your dental care? _____

What is most important to you in your relationship with our office? _____

How do you feel about your overall dental health and well being? _____

If you could change anything about your smile, what would it be? ___ Whiten Teeth ___ Straighten Teeth ___ Lengthen Teeth ___Shorten Teeth ___ Replace Missing Teeth ___ Fix Space Between Teeth ___ Replace Fillings ___ Make Smile Less "Gummy" ___ Everything! Other: _____