Beavers
FAMILY DENTISTRY

WELCOME TO **BEAVERS FAMILY DENTISTRY**

Welcome to our practice. We would like to take a moment to introduce ourselves and extend an invitation for you and your family to visit our office. Beavers Family Dentistry is conveniently located on Highway 55 in Apex across from the United States Post Office.

Our approach to service involves complete patient care. Beavers Family Dentistry combines a casual, relaxed atmosphere with a warm, friendly staff who are always available to answer all of your questions. We pride ourselves in using the most up-to-date and evidence-based technology and procedures to provide our patients with optimal oral health care. A wide variety of dental services are offered including preventive, restorative, and cosmetic dentistry. Please visit our website at beaversfamilydentistry.com to learn more about our office.

When welcoming a new patient to our practice, we also welcome any questions you may have about our office policies, insurance, and fees. We work very hard to control the cost of dental care. It is part of our philosophy that quality care should be available to everyone who desires it. Please refer to our financial policy to learn more about questions concerning office policies, insurance, and fees.

Please complete the enclosed registration forms and bring them with you to your scheduled appointment. **We look forward to meeting you.**

Jonathan P. Beavers Leah G. Beavers Mark E. Beavers

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ○ Policy Holder ○ Responsible Party Preferred Name: _____

RESPONSIBLE PARTY (if someone other than patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Birth Date: _____ Social Security: _____

PATIENT INFORMATION

Address: _____

City, State, Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Birth Date: _____ Social Security: _____

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

Email: _____ ○ I would like to receive correspondence via email.

Employment Status: ○ Full Time ○ Part Time ○ Retired

PRIMARY INSURANCE INFORMATION

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

Insured Social Security: _____ Insured Date of Birth: _____

Employer: _____ Insurance Company: _____

SECONDARY INSURANCE INFORMATION

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

Insured Social Security: _____ Insured Date of Birth: _____

Employer: _____ Insurance Company: _____

Beavers Family Dentistry Apex

Children's Medical Form

Patient Name: Birth Date: Date Created:

Allergies

Does your child have allergies to any of the following?

Medications	◯ Yes ◯ No	Seasonal	◯ Yes ◯ No	Tree or Tree Nut	◯ Yes ◯ No
Peanuts	◯ Yes ◯ No	Metal	◯ Yes ◯ No	Latex	◯ Yes ◯ No
Dyes	◯ Yes ◯ No	Other	◯ Yes ◯ No		

List:

Medical

Has your child experienced problems with any of the following?

Blood Transfusions	◯ Yes ◯ No	TB	◯ Yes ◯ No	Hyperactivity/Attention Deficit	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	HIV Positive	◯ Yes ◯ No	Heart Disease	◯ Yes ◯ No
Celiac Disease	◯ Yes ◯ No	Jaundice	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
Cerebral Palsy	◯ Yes ◯ No	Kidney/Liver Disorder	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Lung Problems	◯ Yes ◯ No	Bleeding Disorder	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Mental Disorders	◯ Yes ◯ No	Tonsils/Adenoids	◯ Yes ◯ No
Epilepsy/Seizures	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Hepatitis A, B, or C	◯ Yes ◯ No
Fainting	◯ Yes ◯ No	Seizures	◯ Yes ◯ No	Speech Disorder	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Hearing Disorder	◯ Yes ◯ No	Autism	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Other	◯ Yes ◯ No

If yes to any of the above, please explain:

Does your child need antibiotic premedication prior to dental visits? ◯ Yes ◯ No

List any medications your child takes:

What is your main concern about your child's dental health?

Signature

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 the patient's health.
It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

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Children's Dental History

Date _____ Name _____ Nickname _____

Age _____ Date of Birth _____ Parent Here Today _____

Please estimate your child's daily exposure to the following items:

Soda _____ Cereal Bars/Granola Bars _____ Dried Fruit _____

Juice _____ Gummies/Gummy Vitamins _____ Cookies/Crackers _____

Sports Drinks _____ Fruit Snacks/Fruit Roll-Ups _____

Was your child: ____ Breast Fed What age did they stop _____

____ Bottle Fed What age did they stop _____

____ Sleep with or go to bed with a milk bottle?

____ Yes ____ No Has your child ever been to the dentist? Date of Last X-Rays _____

Name of Dentist and Date _____

____ Yes ____ No Has your child had any dental treatment? _____

____ Yes ____ No Has your child experienced any unfavorable reaction or anxiety to previous dental care?

____ Yes ____ No Has your child ever used nitrous oxide (laughing gas) or sedation for dental treatment?

If yes, did they tolerate it well and at what age? _____

Does your child suck a finger, thumb or pacifier? _____

Does your child have pain with chewing, or going to sleep at night? _____

Has your child had any trauma to their teeth? _____

Please check if your child is having problems with any of the following:

_____ Cavities _____ Toothache _____ Sensitive Teeth _____ Broken Teeth

_____ Trauma to Teeth _____ Gum Infection _____ Color of Teeth _____ Other _____

____ Yes ____ No Has your child been treated or evaluated by an orthodontist?

Name of Orthodontist _____

____ Yes ____ No Is your home water supply fluoridated?

____ Yes ____ No Does your child use fluoride toothpaste or a fluoride mouth rinse?

____ Yes ____ No Does your child wear retainers or sports guard?

____ Yes ____ No Is your child or a direct family member congenitally missing teeth?

____ Yes ____ No Does your child brush twice daily? (With parent help? ____ Yes ____ No)

____ Yes ____ No Does your child floss once per day? (With parent help? ____ Yes ____ No)

____ Yes ____ No Would you like your child or parent to have instructions on how to clean their teeth?

What is your child's favorite character or favorite sport or activity? _____

BEAVERS FAMILY DENTISTRY **HIPPA 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 healthcare 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, 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 for 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 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 of 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's practice has taken an action in reliance on the use or disclosure indicated in this 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 and receive confidential communications from us by alternate means or at an alternate 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 state 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 complain to 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.

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 to with our HIPAA Compliance Officer in person or by phone at our Main Phone Number 919-362-0967.

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

Print Name: _____ Signature: _____ Date: _____

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Authorization to Release Information

I, _____ (responsible party) give Beavers Family Dentistry authorization to discuss any information regarding the dental visit or account for_____ with the following people:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Signature: _____ Date: _____

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BEAVERS FAMILY DENTISTRY **FINANCIAL POLICY**

All of us at Beavers Family Dentistry are happy to have you as a patient. We are committed to providing you with the highest quality dental care using only the best technology and materials available in the market today. Dental treatment is an excellent investment in an individual's medical care and emotional well-being. It is our goal to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile. Let us take a moment to review the financial policy of our practice.

As a courtesy to you, we can accept assignment of benefit payments from many insurance companies. This step will reduce your immediate, out-of-pocket expenditures. The outlined estimate we provide is based on limited information obtained from your insurance company. We expect you to pay your estimated share of the total fee at your visit. Dental insurance rarely pays all of the charges, and you are always responsible for the total amount. The fees charged for services rendered are the usual and customary fees charged to all of our patients for similar services.

Insurance coverage varies greatly between policies, and your policy may base its allowance on a fee schedule that might not coincide with our fees. Insurance usually covers 80%-100% of simple care (cleanings, x-rays, exams, etc.) and 50% of major work (onlays, crowns, etc.) However, these figures can be altered significantly by the tenets of differing plans. Please feel free to ask about any financial concerns you may have, including insurance estimations.

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.

We accept cash, check, VISA, and Mastercard as options to meet your portion of the fee. Many emergency and cosmetic procedures require full payment at time of service. In addition, other financial options are available for our patients. These arrangements must be made with a financial coordinator prior to scheduling your treatment.

We value you as a patient of our practice. Our goal is to avoid any misunderstandings by informing you of our policies. If you have any questions about your financial obligations, please feel free to discuss them with any of our dedicated staff members.

Sincerely,

Jonathan P. Beavers Leah G. Beavers Mark E. Beavers

Patient/Guardian Signature: _____ **Date**: _____

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Missed Appointment Policy

We would like you to know that at Beavers Family Dentistry it is not a practice of ours to "double book" patients unless it is a circumstance of true emergent need. When you reserve an appointment in advance, your dentist and our individual staff member are waiting to serve your needs, which is why we strongly suggest scheduling your appointment at a time you are available. Our efforts to remind you of your scheduled visit include text, email, phone call and/or postcard. If you are not getting a reminder, please call our office to ensure that we are maintaining your correct contact information.

Our attendance policy at Beavers Family Dentistry is as follows:

1. The first time a patient is unable to attend a pre-reserved appointment without calling the office 24 hours in advance, there is no consequence. Simply call the office to reschedule at your earliest convenience, keeping in mind that the next available preventive cleaning appointment may be 6 months away.

2. The second time a patient is unable to attend a pre-reserved appointment without calling the office 24 hours in advance; the individual patient's account will be deactivated. If the patient chooses to continue to be a patient of record at Beavers Family Dentistry, there will be a $50 reactivation fee, per patient, to schedule a pre-reserved appointment time.

3. The third time a patient is unable to attend a pre-reserved appointment without calling the office 24 hours in advance, the patient may be seen on a "day of" basis to meet the needs of their unpredictable schedule. A patient may call in the morning and if there is an available time slot that day, they may reserve the appointment.

Patient/Guardian Signature: _____ Date: _____