



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
Eaglesoft Medical History**

Patient Name: _____

Birth Date: _____

Date Created: _____

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?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No	
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No	

Women: Are you...

<input type="checkbox"/> Pregnant/Trying to get pregnant?	<input type="checkbox"/> Nursing?	<input type="checkbox"/> Taking oral contraceptives?
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Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local Anesthetics

Other?	<input type="checkbox"/>	If yes _____
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
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Comments:

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: _____

X



DENTAL HISTORY

How did you hear about us? _____

What is the purpose of today's visit? _____

How long since your last dental visit? _____

What treatment did you receive? _____

Previous Dentist's Name: _____

Address: _____ Phone: _____

What did you like most about your last dentist? _____

Would you like to tell us anything else about your previous dental experience? _____

How long has it been since you had your teeth professionally cleaned? _____

Please Circle Yes/No

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, when and how were they replaced? _____

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?Yes No

Are any of your teeth sensitive to: ___ Hot? ___ Cold? ___ Sweet? ___ Pressure? ___ Biting?

Do your gums bleed or hurt?.....Yes No

If yes, when? _____

How often a day do you brush? _____

What type of toothbrush/toothpaste do you use? _____

Do you use a daily mouthwash? If so, what do you use? _____

How often do you floss? _____ What type of floss do you use? _____

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 any complications following dental treatment?Yes No

If so, please explain: _____

Have you ever had orthodontics (braces) ?Yes No

Have you ever taken bisphosphonate medications? (ex: Fosamax).....Yes No

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

Patient/Guardian Signature: _____ Date: _____



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: _____



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: _____



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:** _____



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: _____