# Beasley Family & Implant Dentistry

www.beasleydentistry.com
appointments@beasleydentistry.com

Web - www.BeasleyDentistry.com | 200 East Hobbs St. • Athens, AL 35611 (256)233-1400

**Date:** ____________

**Chart#:** ____________
FOR OFFICE USE ONLY

**Patient Name:** ____________ Last ____________ First ____ MI

____________ Preferred Name

**Title:** ____________ Mr/Ms/Mrs/etc

**Gender:** ◯ Male ◯ Female

**Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

**Birth Date:** ____________

**SS#:** ___-__-____

**Prev. Visit:** ____________

**Email Address:** ____________

**Best time to call:** ____________

**Phone:** ____________ Home ____________ Mobile ____________ Work ______ Ext

____________ Fax ____________ Other

**Address:** ____________ Address 1

____________ Address 2

____________ City ______ State _____-____ Zip Code

**The following is for:** ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

**Employer Name:** ____________

**Phone:** ____________

**Employer Address:** ____________ Address 1

____________ Address 2

____________ City

______ State _____-____ Zip Code

How were you referred to our office?

____________

**Emergency Contact name and phone number:**

**The following is for:** ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

**Name:**

Last | First | MI

Preferred Name

**Title:** Mr/Ms/Mrs/etc

**Gender:** ◯ Male ◯ Female

**Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

**Birth Date:**

**SS#:** ___-__-____

**DL#:**

**Email Address:**

**Best time to call:**

**Phone:**

Home | Mobile | Work | Ext

Fax | Other

**Address:**

Address 1

Address 2

City | State | Zip Code _____-____

**The following is for:** ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

**Employer Name:**

**Phone:**

**Employer Address:**

Address 1

Address 2

City

State | Zip Code _____-____

**Dental History**

**When was your last dental cleaning, exam and x-rays? Who was the providing dentist?**

**What is your present dental complaint?**

## MEDICAL HISTORY

**Are you in good health?** ◯ Yes ◯ No

**If Applicable: Has there been any change in your health history since your last visit?**

**Please list your primary physician's name and phone number:**

**Are you under the care of a physician now? If so, for what conditions?**

**Date of your last physical examination:**

**Have you had any hospitalizations or surgeries within the past 5 years? If so, please list**

**Do you have any existing illnesses? If diabetic, list type I or II and last HbA1c reading:**

**Please list ANY medications or over the counter medicines or supplements that you are taking:**

**Please list your pharmacy and phone number:**

**Have you ever had rheumatic fever or had any artificial joint placed? If so, when?**

**Do you smoke / use tobacco? If so, # of cans / day or packs / day:**

**Do you currently use a CPAP for sleep apnea?** ◯ Yes ◯ No

**Do you or have you ever taken Zometa, Aredia, Boniva, Reclast,Fosamax, or Actonel?** ◯ Yes ◯ No

**Have you ever undergone treatment for drug or alcohol abuse?** ◯ Yes ◯ No

**Ladies: Are you pregnant, trying to get pregnant or think you may be pregnant? If yes, when is your due date?**

______________________________________________________________________

______________________________________________________________________

**Ladies: Are you currently taking birth control pills? If so please list?**

______________________________________________________________________

______________________________________________________________________

**Do you have or have you ever had any of the following?**

| | | | |
|---|---|---|---|
| ☐ Abnormal bleeder | ☐ Allergy - other ____ | ☐ Allergy - Penicillin | ☐ Allergy-Anesthetics |
| ☐ Allergy-Ibuprofen | ☐ Allergy-Latex | ☐ Allergy-Metals | ☐ Allergy-Other Drugs |
| ☐ Allergy-Tylenol | ☐ Anemia | ☐ Antibiotic Pre-med | ☐ Arthritis/Rheumatism |
| ☐ Artificial Joints | ☐ Asthma | ☐ Asthma | ☐ Auto-Immune Disorder |
| ☐ Blood Disease | ☐ Blood Thinners | ☐ Cancer | ☐ Chemotherapy |
| ☐ Coughing Blood | ☐ Debrox | ☐ Dementia | ☐ deorants |
| ☐ Diabetes | ☐ Drug/Alcohol Abuse | ☐ Epilepsy/Seizures | ☐ Fainting/Dizziness |
| ☐ GERD | ☐ Glaucoma | ☐ Gum Treatment | ☐ Hay Fever/Sinus |
| ☐ Head Injuries | ☐ Heart Condition | ☐ Heart Disease | ☐ Heart Murmur |
| ☐ Heart Stents | ☐ Heart Surgery | ☐ Hepatitis | ☐ High Blood Pressure |
| ☐ High Cholesterol | ☐ HIV/AIDS | ☐ Hypothyroid | ☐ Intestinal Problems |
| ☐ Kidney Disease | ☐ Liver Disease | ☐ Mental Disorders | ☐ MVP |
| ☐ Nursing Now | ☐ Osteoporosis | ☐ Other specify_______ | ☐ Pacemaker |
| ☐ Penicillin | ☐ Persistant Cough | ☐ Pneumonia | ☐ Pregnant Now |
| ☐ Radiation Treatment | ☐ Respiratory Problems | ☐ Rheumatic Fever | ☐ Schizophrenia |
| ☐ Soaps | ☐ Stomach ulcer/GERD | ☐ Stroke | ☐ Thyroid problems |
| ☐ TMJ | ☐ Tobacco Use | ☐ Trouble Swallowing | ☐ Tuberculosis (TB) |
| ☐ Tumors | ☐ Venereal Disease | | |

**Please list any other drugs, food, or medications that you are allergic to:**

______________________________________________________________________

______________________________________________________________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health history and medication.

Signature ______________________________________________

**Date** ______________________________________________

**Response Date:** ____________

## OUR POLICIES ARE AS FOLLOWS:

*** Please initial next to each statement, showing that you understand and are aware of the following policies.

## Payments and Insurance:

- ______When verifying benefits, it is never a guarantee of payment per your insurance company's disclaimer. You are responsible for **ALL** copays, deductibles, co-insurance amounts and non-covered services. All co-pays are due at the time of service. **YOU** are ultimately responsible for payment of charges from our office.
- ______It is **YOUR** responsibility to provide accurate insurance information and to present any updated insurance cards upon checking in for your appointment.
- ______If your plan requires an insurance referral, it is your responsibility to obtain this prior to being seen.
- ______It is our desire to help you as much as possible with claims that are submitted to your insurance company. If procedures are done in the office that are deemed non-covered by your insurance company, you will be responsible for payment.
- We are contracted with the following insurance companies: BCBS of AL, Delta Dental (Premier Plan), Southland National, Guardian, Aetna, Principal, Ameritas, Cigna Healthsprings/ Dentaquest, Anthem BCBS and some United Concordia plans. If we are not in network we will be happy to file your insurance. Please be aware that you will be financially responsible for the difference between our fees and what your insurance company pays.
- ______For our patients without insurance please understand that full payment is due the day treatment is rendered. We gladly accept cash, personal checks, and all major credit cards. Also, please ask us about financing options.
- ______The long term success of dental treatment we provide for you depends on your in home and in office dental care. Failure to maintain good home care and minimum 6 month cleanings and exams in our office will void your dental warranty.
- ______All unpaid previous balances must be paid in full prior to making any additional appointments, unless arrangements have been made with the billing office
- ______There is a 25% deposit required for **ALL** appointments that are over 1 hour long. This deposit will be due approximately 1 week prior to your appointment. The appointment will **NOT** be confirmed until this deposit is made.
- ______The RETURNED CHECK fee is $ 30.00

### CANCELLATIONS AND NO-SHOWS:

- ______When an appointment is scheduled, that time has been set aside for you and cannot be used to treat another patient. Cancellations for appointments must be received 48 hours prior to the scheduled appointment.
- ______Patients who fail to keep scheduled appointments will be charged a $30 no-show/late cancellation fee. Continued no-shows will require a $30 deposit prior to another appointment being made.

Patient Signature: ______________________________________ Date:_______________

BEASLEY Family & Implant DENTISTRY

Cosmetic • Laser • Sedation

______***I authorize*** the release of my dental records from Beasley Family & Implant Dentistry and/or individuals involved in my dental care. I further authorize the release of records from any individuals to Beasley Family & Implant Dentistry.

______***I authorize*** insurance payments to be made directly to Beasley Family & Implant Dentistry. I understand I am responsible for any unpaid balance.

______***I am aware*** that should I not provide adequate notice to change an appointment, I may be charged a fee. (48 hours, weekend cancellations do not provide 48 hours' notice).

______***I am aware*** of and have received notice of the Health Insurance Portability and Accountability Act (HIPAA).

## Notice of Privacy Practice – Acknowledgment

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by scheduling an appointment.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

## Authorization for Appointment Confirmation & Office Communications

As a courtesy to our patients, we often will give a variety of appointment reminders. Some of these reminders may generally include, but are not limited to, messages left with roommates/family members, voicemail messages, text messages, and emails. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's appointment time and date, or need for an appointment may be included.

**By my signature below, I authorize Beasley Family & Implant Dentistry and staff to confirm my appointments and remind me of the need for an appointment in the above-mentioned ways, for the duration of my treatment with their office.**

## Authorization to Discuss Treatment & Financial Information

By my signature below, I authorize Beasley Family & Implant Dentistry and staff to discuss treatment and financial information with the people named below for the duration of my treatment with their office.

Name:________________________________Relationship to Patient:__________________________Cell Phone:______________

Name:________________________________Relationship to Patient:__________________________Cell Phone:______________

◯ I do not authorize BFAID to discuss treatment and financial information with anyone other than myself.

**Patient Name (PRINTED PLEASE)** _____________________________________________

**Patient/Legal Custodian Signature:** _______________________________________________**Date:**_____________

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