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: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

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: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

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
- [ ] Acid Reflux
- [ ] Allergy - other ____
- [ ] Allergy-Anesthetics
- [ ] Allergy-Other Drugs
- [ ] Allergy-Penicillin
- [ ] Antibiotic Pre-med
- [ ] Anxiety
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Thinners
- [ ] COVID-19 Vaccination
- [ ] Cancer
- [ ] Dementia
- [ ] Depression
- [ ] Diabetes
- [ ] Drug/Alcohol Abuse
- [ ] Epilepsy/Seizures
- [ ] GERD
- [ ] Glaucoma
- [ ] Grapes
- [ ] HIV/AIDS
- [ ] Hay Fever/Sinus
- [ ] Head Injuries
- [ ] Heart Condition
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Stents
- [ ] Heart Surgery
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Kidney Disease
- [ ] Mental Disorders
- [ ] Muscular Dystrophy
- [ ] Nursing Now
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Pneumonia
- [ ] Pregnant Now
- [ ] Radiation Treatment
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] Steroids
- [ ] Stomach problems
- [ ] Stomach ulcer/GERD
- [ ] Stroke
- [ ] TMJ
- [ ] Thyroid problems
- [ ] Tobacco Use
- [ ] Tuberculosis (TB)
- [ ] Wasps

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: _____

BEASLEY DENTISTRY OFFICE POLICIES FOR PAYMENTS and INSURANCE:

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

- _____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 all 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, 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, Carecredit 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
- _____Our RETURNED CHECK fee is $ 30.00
- _____ Once your account becomes 30 days or more delinquent with no attempt to make payments by you, your account may be turned over to collections. You agree to reimburse our office for the fees of any collection agency, which will be based on an interest rate of up to 8% annually, an initial flat fee of $10.95 when turned over to the collection agency and an additional fee of 21% of the overdue balance should the balance not be paid within the first 60 days from the date of submission to the agency or if your account is submitted directly to the intensive collection efforts of the agency. You also agree to pay all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts.

BEASLEY DENTISTRY OFFICE POLICIES FOR 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 $45 no-show/late cancellation fee. Continued no-shows will require a $45 deposit or more prior to another appointment being made.
- _____Scheduling of any major procedure requires payment of a deposit to schedule your appointment. This deposit will be due approximately 1 week prior to your appointment and the deposit amount is applied to your bill. If you fail to keep your reserved appointment this deposit amount is forfeited. Your appointment will **NOT** be confirmed until this deposit is made and in such case the appointment time will be given to another patient.

Patient Signature: _____ Date: _____

BEASLEY
Family & Implant
DENTISTRY
Cosmetic • Laser • Sedation

Please initial on each line below to indicate you have read and understand the following statements.

_____***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 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 with anyone other than myself.**

Patient Name (PRINTED PLEASE) _____

Patient/Legal Custodian Signature: _____Date:_____

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P: 256.233.1400
F: 256.573.1466

200 E Hobbs St
Athens, AL 35611

Dr. Robert B. Beasley, DMD

Credit Card Authorization Form

In an effort to better serve you, we ask that you take care of the fees for your visit at the time of service. Depending upon the procedure, we may ask for a 25% deposit ahead of your appointment to confirm it. By allowing us credit card authorization, you are giving us permission to keep your card on file and charge any balance due on the date of service and/or a balance which is past due by 30 days. **You will be contacted by the office if any charges or credits will be applied to your credit card.**

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip Code: _____

Credit Card Details:

Card Type: __ Visa __ MasterCard __ American Express __ Discover __ Other: _____

Cardholder Name: _____

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____

Consent: (Check one of the following)

___ I, the undersigned cardholder, **DO** authorize the merchant known as Beasley Family & Implant Dentistry to charge my credit card for purchases related to goods and services. I agree that my information will be saved by the merchant for future payments and understand that this can be revoked at any time with request.

___ I, the undersigned cardholder, **DO NOT** authorize the merchant known as Beasley Family & Implant Dentistry to collect my credit card information for future purchases related to goods and services. I understand that any outstanding balances will collect a 2% per month finance charge on my balance if not paid within 30 days of charge.

Cardholder's Signature: _____ Date: _____