BEAVERS PEDIATRIC DENTISTRY

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Patient Registration Form

TELL US ABOUT YOUR CHILD

Child's Name:________________ Preferred Name:________________ ❑ Male ❑ Female
Child's birthdate:__________ Child's age:________ School:________________ Grade______
Child's home address:________________ Zip______ Child's home number:__________
Social Security #:________________ Siblings Currently at Practice:________________

WHO IS ACCOMPANYING THE CHILD TODAY?

Name:________________ Relation:__________ Do you have legal custody of the child? ❑ Yes ❑ No
Whom does patient live with?:______ In case of emergency, contact other than parent:________________
Whom may we thank for referring you to our office?:________________ Email address:________________
What is the best way for our office to confirm your appointments?: *(Circle One)* Text Cell Home # Email

PERSON RESPONSIBLE FOR ACCOUNT

Mother's Information:

Name:________________ Date of birth: ______
Address:________________ For how long?:______
____
Employed by:________________ For how long?:______
Occupation:________________
SS#:________________
Cell phone #:________________
Business phone #:________________
Home phone #:________________

Father's Information

Name:________________ Date of birth: ______
Address:________________ For how long?:______
____
Employed by:________________ For how long?:______
Occupation:________________
SS#:________________
Cell phone #:________________
Business phone #:________________
Home phone #:________________

DENTAL INSURANCE COMPANY

Insurance Co. Name:________________ Medicaid #__________ United Healthcare #__________
Insurance Co. address: ________________ Insurance Co. phone:__________
Group #:__________ ID #__________ Insured's name:________________

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit references. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Beavers, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

________________________ ________________
SIGNATURE OF PARENT/GUARDIAN DATE

Date: ______________________________

MEDICAL HISTORY

1. Is your child under care of a physician? ❑ Yes ❑ No
   If yes, since when and why? Regular Care ❑ Other ______________
2. Name of physician ______________________________
3. Is your child receiving any medication? ❑ Yes ❑ No
   What? ______________________________
4. Is your child allergic to penicillin, antibiotics or other drugs? ❑ Yes ❑ No
5. Does your child have other allergies? ❑ Yes ❑ No
6. Has your child had any serious illness? ❑ Yes ❑ No
7. Has your child ever had surgery or been hospitalized? ❑ Yes ❑ No
8. Has your child had history of any of the following? **Please check a response for each question:**

Heart trouble, murmur, heart surgery, etc. ❑ Yes ❑ No
Rheumatic fever or scarlet fever ❑ Yes ❑ No
Asthma, TB or lung problems ❑ Yes ❑ No
HIV infection or AIDS ❑ Yes ❑ No
Hemophilia or bleeding problems ❑ Yes ❑ No
Sickle cell anemia/blood disorder ❑ Yes ❑ No
Hepatitis or liver problems ❑ Yes ❑ No
Kidney infection ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Cancer, tumor, leukemia ❑ Yes ❑ No
Thyroid or other glandular problems ❑ Yes ❑ No
Latex or rubber allergy ❑ Yes ❑ No
Frequent headaches ❑ Yes ❑ No
Epilepsy, seizures, fainting ❑ Yes ❑ No
Cerebral palsy or mental retardation ❑ Yes ❑ No
Vision problems ❑ Yes ❑ No
Speech or hearing problems ❑ Yes ❑ No
Emotional or mental problems ❑ Yes ❑ No
Congenital birth defects ❑ Yes ❑ No
Cleft lip or palate ❑ Yes ❑ No
Malignant hyperthermia ❑ Yes ❑ No
Emergency care ❑ Yes ❑ No
Autism ❑ Yes ❑ No
Is parent or patient pregnant? ❑ Yes ❑ No

COMMENTS *(For office use only)*

Med. Alert

Purpose of Today's Visit ______________________________

DENTAL HISTORY

1. When and where was your child's last dental visit? ______________
2. What was the purpose of that visit? ______________
3. Were any x-rays taken at your child's last dental visit? ❑ Yes ❑ No
4. Did your child have difficulty cooperating? ❑ Yes ❑ No
5. Was/is your child bottle fed? ❑ Yes ❑ No
6. Was/is your child breast fed? ❑ Yes ❑ No
7. If your child has been weaned please indicate at what age? ______________
8. Does you child eat between meals? ❑ Yes ❑ No
9. Does your child eat sweets, such as candy, soda, chewing gum? ❑ Yes ❑ No
10. Do you assist/supervise your child's brushing? ❑ Yes ❑ No
11. When does your child brush his/her teeth?
    ❑ upon arising ❑ after eating nay food
    ❑ right after meals ❑ before going to bed
12. Does your child have any form of fluoride? (city or well water, vitamin, rinses, toothpaste) ❑ Yes ❑ No
13. Have any cavities been noted in the past? ❑ Yes ❑ No
14. Were any teeth (baby or permanent) removed by extraction? ❑ Yes ❑ No
15. have there been any injuries to teeth, such as falls, blows, chips, etc.? ❑ Yes ❑ No
16. Has anyone in the family, including parents, had orthodontics? ❑ Yes ❑ No
17. Has your child had a toothache lately? ❑ Yes ❑ No
    If yes, explain: ______________
18. Do you expect your child to be cooperative? ❑ Yes ❑ No

CONSENT

I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest of confidence. Since my child is a minor, it is necessary that signed permission be obtained from a parent or guardian before any and/or all necessary dental services can be performed by Dr. Nathan Beavers. Authorization is hereby granted as such. I understand I will be consulted before any treatment is rendered.

______________________________ ______________________________

SIGNATURE OF PARENT/GUARDIAN DATE

APPOINTMENT POLICY

CONFIRMATIONS

As a courtesy our office will call to confirm your appointment 24 hours in advance. If you have a Monday appointment, we will call the Thursday before to confirm. Please call us back if we leave you a message. An answering machine is available for after hour calls.

RESCHEDULING APPOINTMENTS

If you need to reschedule your appointment call our office 24 hours before your appointment time. Rescheduling your appointment the day of *may* result in a $25 fee.

NO SHOWS

Failure to keep a confirmed appointment will result in a $25.00 fee added to your account.
If you NO SHOW for an extraction, tooth restoration, or sedation appointment, ALL FUTURE SCHEDULED APPOINTMENTS WILL BE REMOVED FROM OUR APPOINTMENT BOOK.

I have read and acknowledge the above appointment policies and understand the fee consequences.

______________________________	______________________________
Signature	**Date**
______________________________	______________________________
Witness	**Date**

NO SHOW / CANCELLATION POLICY

Dr. Nathan K. Beavers, Pediatric Dentistry

Purpose: The Doctors and Staff of Nathan Beavers, Pediatric Dentistry respect your time and we ask the same courtesy in return. Missed appointments and/or checking in late for your appointment affect our ability to provide timely attention to our patients. When the patient does not show up for their appointment, another patient loses the opportunity to be seen. If you are unable to make your scheduled appointment time, we respectfully ask that you notify our office at least **24 hours in advance**.

Missed appointments will be documented in your chart.

- 2 documented cancellations without 24 hours' notice or a no-show to an appointment are grounds for immediate dismissal from Nathan Beavers Pediatric Dentistry office.
- Any unspecified patterns including, but not limited to: continually showing up late for appointment, continually cancelling appointments (even if giving 24 hours' notice) will be grounds for immediate dismissal from our office.
- **Not giving a permanent or reliable phone number to confirm appointments** will also be grounds for dismissal from our office. We must be able to contact you to confirm your child's appointment 24 hours in advance.

I have read the above and understand the office policy. I will do anything I can to assure that I confirm appointments 24 hours prior to and when I have confirmed an appointment, I will arrive on that specified day and time**. Appointments not confirmed 24 hours in advance are subject to be given to another patient. We cannot guarantee your child will be seen if you present late or without prior confirmation for scheduled appointments**.

Patient Name

Parent or Legal Guardian Signature

Date　　　　Witness

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES TO PATIENT, PARENT, OR GUARDIAN OF MINOR PATIENT.

I, ______________________________, patient, parent or guardian of patient, have received a copy of this office's NOTICE OF PRIVACY PRACTICES.

____

Patients Name

____

Guardian's signature

____

Date

You may refuse to sign this acknowledgement

....

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

~ Individual refused to sign

~Communication barriers prohibited obtaining the acknowledgement

~An emergency situation prevented us from obtaining acknowledgement

~Other (please specify)______________________________

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication of this form by any other party requires the prior written approval of the American Dental Association.

This form is educational only, does not constitute legal advice, and covers only federal, not state law (August 14, 2002).

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Nathan K. Beavers, DMD

Pediatric Dentistry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 21, 2005, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time provided such changes are permitted by the applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our policy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Your

Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only of you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you a fee for each page, or for staff time to locate and copy your health information, and postage if you want the copies mailed. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosed Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternate means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice by electronic mail (e-mail), you are entitled to receive this Notice in written form.certain other activities, for the last

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have use communicate with you by alternative means or at alternatives locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department and Human Services upon request.
We support the right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services..

Contact Officer: [signature] DMD
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