Date___ / ___ /_____

WELCOME TO BEACON DENTAL – PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____
Last First
Home Address: _____

_____
Street

_____
City State Zip
Home Phone _____
Cell Phone_____
Work Phone_____
E-mail Address_____
Date of Birth _____Age_____
SS#_____/_____/_____ Sex: M F
Emergency Contact_____

INSURANCE INFORMATION

Insurance Company_____
Responsible Person_____
Relationship to Patient_____
Employer _____
Date of Birth _____Age_____
SS#_____ Sex: M F
Insurance ID: _____
Mailing Address: _____

_____
Street

_____
City State Zip

MEDICAL HISTORY

Physicians Name _____ Phone _____
Date of last visit _____ Have you had any serious illnesses or operations? Y N
If yes, describe _____
Are you currently under physician case? Y N If yes, describe _____
Are you pregnant Y N Nursing? Y N Taking birth control pills? Y N
Check if you have had any of the following:

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ A topic (allergy prone)
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
  Describe_____
  _____
- ☐ Hemophilia/Abdominal
- ☐ bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Jaw Pain
- ☐ Kidney disease /malfunction
- ☐ Liver disease
- ☐ Material allergies (latex, chemicals)
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker/Heart surgery
- ☐ Psychiatric care
- ☐ Rapid weight loss or gain
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic/Scarlet fever
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin Rash
- ☐ Spinal Bifida
- ☐ Stroke
- ☐ Surgical implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease /malfunction
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer, Colitis
- ☐ Venereal disease

List medications you are currently taking, if any:

_____
_____

ALLERGIES: _____

Signature_____

Date: ____/_____/_____

DENTAL HISTROY

What would you like us to do today? _____ Are you in dental discomfort today? _____
Former dentist _____Address_____ Phone _____
Date of last dental care _____ Date of last x-rays _____
Heck if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between
- ☐ Grinding or clenching te
- ☐ Loose teeth or broken
- ☐ Periodontal treatmen
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores/growths

How often do you brush? _____ Floss _____
How do you feel about the appearance of your teeth?
_____
Have you ever experienced and adverse reaction during or in conjunction with a medical/dental procedure? Y N
Other information about your dental health of previous treatment_____

ACKNOWLEDGMENT OF RECIPET OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I provided a copy of the notice of Privacy Practices and that I have read (or had the opportunity to read if no chance) and understand the notice.

_____
Patient Name

_____
Patient or Authorized Representative

AUTHORIZATION

I have reviewed the information in this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services included. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all changes whether or not paid by the insurance.

_____
Signature Date

HOW DID YOU HEAR ABOUT OUR DENTAL PRACTICE

1. Pass by or live near by _____
2. Heard about us from friend or family, Name: _____
3. Insurance Company:
4. Google:
5. Even/School:
6. Other:

WELCOME TO BEACON DENTAL

Our goal is to offer the best quality Dental Care to our patients and help our patient achieve long term dental health. In order to accomplish this, we need to communicate clearly to you our policies regarding appointments and payment for services.

OFFICE POLICY PART (1) – APPOINTMENTS

1. Please inform our office of any changes regarding your insurance, medical conditions, phone number and address.
2. It is your responsibility to keep track of and remember your appointment. As courtesy, we will contact you 4-5 days in advance to contact and confirm your appointment. If you receive a message about this reminder, please give us a call back to let us know you will be here.
3. To reschedule or cancel an appointment, our office needs **48-hour notice.** This is because the time has been reserved for you with the doctor. When you cancel, the doctor is left with a reserved time but no patient. 48-hour notice gives us the best chance of offering that reserved time to another patient.
4. Cancelled or rescheduled appointments without 48-hour notice in advance will be considered a broken appointment. A charge of $50 will be posted to your account. After **2 broken appointments** in 6 month, we have the right to keep or terminate the dentist-patient relationship. Initial_____
5. If a patient is **15 minutes late** for an appointment, our office will decide to reschedule the appointment according to our schedule.

OFFICE POLICY PART (2) – BILLING, FEE & INSURANCE

1. **Payment is due at the time of service.**
   a) For patients with insurance, we are happy to help you process your insurance claim with your carrier. We require the **Estimated** patient portion to be paid at the time of the schedule. When the payment is made by your insurance company, we will adjust your account. If insurance pays less than the estimate, the patient will be responsible for the balance. If insurance pays more than the estimate, the patient will be refunded the difference. Initial_____
   b) For patients without insurance, we require full payment at the time of service.
   c) Payment can be made in the form of cash, check, or credit card. We also offer finance plans from third party to pay for treatment over several months or years.
2. When your insurance downgrades materials used for your treatment you will be responsible for the difference in the cost of materials used routinely at Beacon Dental.
3. We will no longer be submitting claims to secondary insurance, all copays and deductibles must be paid at the time of the visit. You can also request a copy of your EOB if your insurance does not provide you one.
4. Our staff will be happy to submit claims on your behalf to your insurance company. Please be aware that it is your responsibility to check with your insurance company about your policy. The quote given to you by our office is only an **Estimate**. If you have any questions about your payments, we will be glad to discuss them with you. You are responsible for any amount not covered by your insurance company.
5. For an appointment longer than 40 minutes we require 50% down payment and the remaining 50% at the time of the service.
6. We accept Visa, MasterCard, Discover, American Express and personal checks. There will be a charge for returned checks.
7. Any unpaid balance over 30 days from final payment be it an insurance or personal payment will be charged 1.5% Apr 18% yearly. By requiring payment in full at time of service, it is our goal to eliminate unpaid balances and prevent any blemish on your credit record. If we must send your account to a collection company, collection costs and attorney fees will be your responsibility.

Print Name **Signature** **Date**

_____

Beacon Dental, PC

PATIENT HIPAA CONSENT FORM

I understand that as part of my health care, Beacon Dental, PC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization in not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance.

Signed this _____ day of _____ 20_____

Print Patient Name _____

Signature _____

If patient is a minor, relationship to patient _____