PATIENT WELCOME FORM

Welcome to your new dental home. The information on this form is important for our records and for your health. This information is strictly confidential. Thank you.

PERSONAL INFORMATION

Patient's Legal Name: ______________________________ Date of Birth____________ ❒Male ❒Female

Preferred Name______________________________ Home Phone #____________ Cell Phone #______________

Patient's Address: ______________________________ City__________ State_________ Postal Code __________

Social Security Number__________________________ Driver's License Number ____________________________

E-mail______________________________ Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed

If Student, list of name of School/College____________________ City__________ State________

Patient/Guardian's Employer__________________________ Occupation________________________________

Work Address: ____ Phone # ______________________

Spouse's Name: ____________________________ Spouse's Employer____________ Occupation ______________

Spouse's Work Address:____ Phone # ______________________

Do you have other family members who are patients here? ____

Who can we thank for referring you to our office?____

EMERGENCY CONTACT INFORMATION

Name______________________________________ Relationship____

Home Phone #______________________ Work Phone #______________________ Cell Phone #__________________

INSURANCE AND FINANCIAL INFORMATION

Do you have insurance coverage? ❒No ❒Yes - Insurance Company Name____________________ Phone #______________

Insured Name____________________ SS#____________ Patient's Relationship to Subscriber ❒Self ❒Spouse ❒Guardian

Insured Birthdate____________ Group Cert/ID #__________ Division #_____________ Group/Policy #________________

Employer (if different from above)______________________ Employer Address____________________________________

Do you have secondary coverage? ❒No ❒Yes - Insurance Company Name___________________ Phone #______________

Insured Name____________________ SS#____________ Patient's Relationship to Subscriber ❒Self ❒Spouse ❒Guardian

Insured Birthdate______________ Group Cert/ID #_____________ Division #____________ Group/Policy #____________

Employer (if different from above)____________________ Employer Address__________________________________

BEARDEN FAMILY DENTISTRY

PATIENT WELCOME FORM

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RESPONSIBLE PARTY

Name of person responsible for this account_______________________________________Relationship___________________

Address: Street, Ste #____________________________City________State________Postal Code_____Phone #____________

Home Phone #_________________________Work Phone #________________________Cell Phone #____________________

RELEASE INFORMATION

You may discuss my health care with...

Health Care Providers ❒Yes ❒No Insurance Companies ❒Yes ❒No Others (Spouse, Parents, etc.) ____________________

____

____

ASSIGNMENT AND RELEASE

- We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, further disease, and misunderstandings. Therefore, if a plan is agreed upon and started, it should be completed.
- Dental insurance is designed to help aid in attaining optimum dental health; it is not designed to be a 'pay-all'. It is in your best interest to be sure that we have all of your current insurance information on file. We will do our best to answer any questions you have and are happy to process your claim forms at no charge.
- We schedule your appointments to your convenience, and your punctuality is appreciated. If you need to reschedule your appointment, please provide us with two working days' notice, in which case no cancellation fee will be applied. **No show or last-minute cancellations without approved circumstances will result in a $75 cancellation fee.**
- I understand that I am responsible for payment of services rendered and that payment is due in full at the time of treatment unless prior arrangements have been approved. In the event payments are not received when agreed upon, 1.5% per month interest and if necessary, collection and/or legal fees of 50% will be added to the balance due. I hereby authorize release of any information, either in print or electronic media, including the diagnosis and records of treatment or examination rendered, to my insurance company.
- I hereby authorize payment directly to BEARDEN FAMILY DENTISTRY for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
- I authorize the above doctor and/or any provider or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature Patient/Guardian____Date__________________________________

Witness Signature____Date__________________________________

BEARDEN FAMILY
DENTISTRY

DENTAL / MEDICAL HISTORY

PERSONAL INFORMATION

Name: ____ Date of Birth: __________________

DENTAL INFORMATION

What is the reason for today's visit? ❒ Full Exam ❒ Emergency ❒ Consultation

Are you in pain? ❒Yes ❒No If yes, for how long and in what area? ____________________________________

Former Dentist_______________________City, State__________________Last Dental visit date__________

Date of last Oral X-rays___________How often do you floss?____________How often do you brush?__________

Type of toothbrush bristles do you use? ❒Hard ❒Medium ❒Soft Do you require premedication? ❒Yes ❒No

How do you rate your smile, 1 – 10? _____ What would you like to improve?_____________________________

Check all that apply:

Bad Breath	❒Yes ❒No	Loose teeth or broken filling	❒Yes ❒No	Sensitivity to sweets	❒Yes ❒No
Bleeding gums	❒Yes ❒No	Orthodontic Treatment	❒Yes ❒No	Sensitivity when biting	❒Yes ❒No
Blisters on lip/mouth	❒Yes ❒No	Pain around ear	❒Yes ❒No	Frequent headaches	❒Yes ❒No
Fingernail biting	❒Yes ❒No	Periodontal Treatment	❒Yes ❒No	Jaw, head or neck injuries	❒Yes ❒No
Grinding teeth	❒Yes ❒No	Sensitivity to cold	❒Yes ❒No	Jaw clicking and/or pain	❒Yes ❒No
Lip and cheek biting	❒Yes ❒No	Sensitivity to heat	❒Yes ❒No	Tooth pain	❒Yes ❒No

MEDICAL INFORMATION

Physicians Name: ____ Date of Last Visit: ______________

Are you currently under medical treatment? ❒Yes ❒No If yes, for what? ______________________________

Do you use Tobacco? ❒Yes ❒No If yes, what and for how long? ____________________________________

Do you use Illicit drugs? ❒Yes ❒No If yes, what? ____

Are you pregnant? ❒Yes ❒No Are you nursing? ❒Yes ❒No

Have you had an allergic reaction to any of the following?

Local Anesthetics	❒Yes ❒No		
Penicillin or other Antibiotics	❒Yes ❒No		
Sulfa Drugs	❒Yes ❒No		
Barbiturates and/or Sedatives	❒Yes ❒No		
Sleep Apnea	❒Yes ❒No	If "Yes" do you wear a CPAP?	❒Yes ❒No
Lodine	❒Yes ❒No		
Aspirin	❒Yes ❒No		
Latex	❒Yes ❒No		

Are you currently taking any medications? If yes, please list: ____________________________________

____

Please list any other surgeries or medical conditions you have ever had: ___________________________

____

MEDICAL INFORMATION - continued

Please mark any that apply:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS	❒Yes	❒No	Diabetes	❒Yes	❒No	Nervous Problems	❒Yes	❒No
Anemia	❒Yes	❒No	Emphysema	❒Yes	❒No	Pacemaker	❒Yes	❒No
Arthritis	❒Yes	❒No	Epilepsy	❒Yes	❒No	Psychiatric care	❒Yes	❒No
Artificial Heart Valves	❒Yes	❒No	Fainting/Dizzy	❒Yes	❒No	Radiation	❒Yes	❒No
Artificial Joints	❒Yes	❒No	Glaucoma	❒Yes	❒No	Respiratory	❒Yes	❒No
Asthma	❒Yes	❒No	Headaches	❒Yes	❒No	Rheumatic Fever	❒Yes	❒No
Back Problems	❒Yes	❒No	Heart Murmur	❒Yes	❒No	Scarlet Fever	❒Yes	❒No
Bleeding abnormally,	❒Yes	❒No	Heart Problems	❒Yes	❒No	Shortness of breath	❒Yes	❒No
with surgery/extractions	❒Yes	❒No	Hepatitis	❒Yes	❒No	Sinus Trouble	❒Yes	❒No
Blood Disease	❒Yes	❒No	Herpes	❒Yes	❒No	Skin Rash	❒Yes	❒No
Cancer	❒Yes	❒No	High Blood Pressure	❒Yes	❒No	Stroke	❒Yes	❒No
Chemical Dependency	❒Yes	❒No	HIV Positive	❒Yes	❒No	Swelling of feet/ankles	❒Yes	❒No
Chemotherapy	❒Yes	❒No	Jaundice	❒Yes	❒No	Swollen Neck Glands	❒Yes	❒No
Chronic Fatigue Synd.	❒Yes	❒No	Jaw Pain	❒Yes	❒No	Thyroid Problems	❒Yes	❒No
Circulatory problems	❒Yes	❒No	Kidney Disease	❒Yes	❒No	Tonsillitis	❒Yes	❒No
Congenital Heart Issues	❒Yes	❒No	Liver Disease	❒Yes	❒No	Tuberculosis	❒Yes	❒No
Cortisone Treatment	❒Yes	❒No	Low Blood Pressure	❒Yes	❒No	Tumor/growth on head	❒Yes	❒No
Cough-persistent	❒Yes	❒No	Mitral Valve Prolapse	❒Yes	❒No	Ulcer	❒Yes	❒No
Taken Bisphosphonates	❒Yes	❒No	Venereal Disease	❒Yes	❒No	Human Papilloma Vaccine	❒Yes	❒No

- ❖ We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- ❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ❖ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Please advise us in the future of any change in your dental or medical history or any medications you may be taking.

Patient/Guardian Signature: ____ Date: ____________________

Witness Signature: ____ Date: ___________________

COVID-19 Pandemic
Dental Treatment Consent Form

Even after following protocols set by the American Dental Association and our state's dental association, it is still possible to contract COVID-19 while at a dental office. We are following all guidelines to minimize the risk of transmission.

- I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious. _______ (Initial)
- I understand that – due to the frequency of visits of other dental patients, the characteristics of the COVID-19 virus, and the characteristics of dental procedures – I have an elevated risk of contracting the COVID-19 virus simply by being in a dental office. _______ (Initial)
- I confirm that I am not presenting any of these COVID-19 symptoms: _______ (Initial)
    - Fever
    - Shortness of breath
    - Dry cough
    - Runny nose
    - Sore throat
- I confirm that I have not been in contact with a person who has been diagnosed with COVID19 within the past 14 days. _______ (Initial)
- I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least six feet for a period of 14 days to anyone who has recently traveled, and this is not possible with dentistry. _______ (Initial)
- I verify that I have not traveled outside the United States in the past 14 days. _______ (Initial)
- I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days. _______ (Initial)

Printed name: ____________________________________ Date of birth: ______________
(Patient) (Patient)

Signature: ____________________________________ Today's date: ______________
(Patient or legal guardian)

BEARDEN FAMILY
DENTISTRY

Acknowledgment: Receipt of Notice of Privacy Practices

I have received a copy of the *Notice of Privacy Practices* from:

Practice Name

Effective Date

Patient Acknowledgment

Patient Name (Please Print)

Patient Signature

Effective Date

Personal Representative Acknowledgment

I am the personal representative of:

Patient Name (Please Print)

I have received a copy of the *Notice of Privacy Practices* from:

Practice Name

Personal Representative Signature

Effective Date

Personal Representative (Please Print)

Relationship to Patient

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my care).
- Obtaining payment from third party payers (e.g., my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient or Legal Representative Signature

____ ________________
Signature of patient or legal representative Date

____
Printed name of legal representative

____
Relationship to patient

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

____ ________________
Signature of patient or legal representative Date