PATIENT REGISTRATION

Patient's First Name: ______________________ **Last Name:** ______________________

How did you hear about us? ____

PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Street Address: ____

City, State, Zip: ______________________ Email: ______________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Sex: ___Male ___Female Marital Status: ___Married ___Single ___Divorced ___Separated ___Widowed

Birth Date: __________ Age: _____ Soc. Sec: ______________ Drivers Lic: ______________

Employment Status: ___Full Time ___Part Time ___Retired

Student Status: ___Full Time ___Part Time

Responsible Party (if someone other than the patient)

First Name: ______________________ Last Name: ______________________

Street Address: ____

City, State, Zip: ______________________ Email: ______________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Birth Date: __________ Age: _____ Soc. Sec: ______________ Drivers Lic: ______________

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: ______________________ Relationship to Patient: ___Self ___Spouse ___Child

Social Security: ______________________ Insured Birth Date: ______________

Employer: ______________________ Insurance Company: ______________________

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured: ______________________ Relationship to Patient: ___Self ___Spouse ___Child

Social Security: ______________________ Insured Birth Date: ______________

Employer: ______________________ Insurance Company: ______________________

MEDICAL HISTORY

PATIENT NAME ____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? __Yes __No ____________
Have you ever been hospitalized or had a major operation? __Yes __No ____________
Have you ever had a serious head or neck injury? __Yes __No ____________
Are you taking any medications, pills, or drugs? (Please List) __Yes __No ____________
Do you take or have you taken, Phen-Fen or Redux? __Yes __No ____________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? __Yes __No ____________
Are you on a special diet? __Yes __No ____________
Do you use tobacco? __Yes __No ____________
Do you us controlled substances? __Yes __No ____________

Women: Are you ______Pregnant? ______Trying to get pregnant? ______Nursing? ______Taking oral contraceptives?

Are you allergic to any of the following:

__Aspirin __Penicillin __Codeine __Acrylic __Metal __Latex __Local Anesthetics __Sulfa drugs __Other

Do you have, or have you had any of the following?

__AIDS/HIV Positive	__Chest Pains	__Frequent Headaches	__Irregular Heartbeat	__Scarlet Fever
__Alzheimer's Disease	__Cold Sores/Fever Blisters	__Genital Herpes	__Kidney Problems	__Shingles
__Anaphylaxis	__Congenital Heart Disorder	__Glaucoma	__Leukemia	__Sickle Cell Disease
__Anemia	__Convulsions	__Hay Fever	__Liver Disease	__Sinus Trouble
__Angina	__Coilisone Medicine	__Heart Attack/Failure	__Low Blood Pressure	__Spina Bifida
__Arthritis/Gout	__Diabetes	__Heart Murmur*	__Lung Disease	__Stomach/ Intestinal Disease
__Artificial Heart Valve*	__Drug Addiction	__Heart Pace maker*	__Mitral Valve Prolapse*	__Stroke
__Artificial Joint*	__Easily Winded	__Heart Trouble/Disease	__Pain in Jaw Joints	__Swelling of Limbs
__Asthma	__Emphysema	__Hemophilia	__Parathyroid Disease	__Thyroid Disease
__Blood Disease	__Epilepsy or Seizures	__Hepatitis A	__Psychiatric Care	__Tonsillitis
__Blood Transfusion	__Excessive Bleeding	__Hepatitis B or C	__Radiation Treatments	__Tuberculosis
__Breathing Problem	__Excessive Thirst	__Herpes	__Recent Weight Loss	__Tumors or Growths
__Bruise Easily	__Fainting Spells/Dizziness	__High Blood Pressure	__Renal Dialysis	__Ulcers
__Cancer	__Frequent cough	__Hives or Rash	__Rheumatic Fever*	__Venereal Disease
__Chemotherapy	__Frequent Diarrhea	__Hypoglycemia	__Rheumatism	__Yellow Jaundice

Have you ever had any serious illness not listed above? ______Yes ______No ______N/A

Comments: ____________________

____

**Condition may require medication* *N/A-Not answered by patient.*

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian Signature: ____________________ **Date:** ____________

DENTAL HISTORY

What is the purpose of today's visit? ______

How long since your last visit? ______

What treatment did you receive? ______

Previous dentist's name: ______

Address: ______ Phone: ______

How long since you have had your teeth cleaned? ______

Please circle Yes or No for the following questions:

Have you made regular visits? ______ Yes No

How often? ______

Were dental radiographs taken? ______ Yes No

Have you ever lost teeth or had them removed? ______ Yes No

Why? ______

Have they been replaced? ______ Yes No

If so, how were they replaced?

___ Fixed Bridge ___ Removable Partial ___ Full Denture ___ Implant Therapy Age ______

Are you unhappy with the replacement? ______ Yes No

If yes, please explain: ______

Would you like to discuss replacement options? ______ Yes No

Do you clench or grind your teeth? ______ Yes No

Does your jaw click or pop? ______ Yes No

Have you experienced pain or soreness in the muscles of your face or around your ear? ______ Yes No

Do you have frequent headaches, neck pain or shoulder aches? ______ Yes No

Does food ever get caught between your teeth? ______ Yes No

Are any of your teeth sensitive to: ___ Hot? ___ Cold? ___ Sweets? ___ Pressure? ___ Biting?

Do your gums bleed or hurt? ______ Yes No

If yes, when? ______

How often do you brush? ______ Floss? ______

Do you have any loose, broken or shifted teeth? ______ Yes No

Are you unhappy with the appearance of your teeth? ______ Yes No

Is there anything you would like to change about your teeth? ______ Yes No

Have you ever had gum treatment or surgery? ______ Yes No

If yes, when? ______ What was done? ______

Have you ever had orthodontics (braces)? ______ Yes No

Have you ever had any complications following dental treatment? ______ Yes No

If so, explain: ______

Do you have anything about dentistry that you strongly dislike or have any unpleasant experiences or concerns?

______

Patient/Guardian Signature: ______

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows Wayne M. Beavers, DDS, PA (Name of Practice) to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: ______________________________
(Last) (First) (Middle Initial)

Date of Birth: ____________ mm/dd/yyyy **Main Contact Number:** ( ) ____________
☐ Home ☐ Cell* ☐ Work

Mailing Address: ______________________________
(Street)

____
(City) (State) (Zip)

COMMUNICATING WITH YOU

PHONE	**DETAILED MESSAGES PERMITTED**		
☐ Main Contact Number Above	☐ text (SMS)*	☐ voicemail/answering machine	☐ None
☐ Other: ( ) ____________ ☐ Home ☐ Cell* ☐ Work	☐ text (SMS)*	☐ voicemail/answering machine	☐ None

EMAIL*

☐ ______________________________

☐ All information from this practice
☐ Appointment information only (request/confirm/cancel)
☐ Data breach notifications
☐ Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse/Partner: ____________ First and Last Name	Other: ____________ First and Last Name
Phone: ( ) ____________	Phone: ( ) ____________
Email:* ____________	Email:* ____________
	Relationship: ____________

Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance

☐ Other: ______________________________

Do not include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

Rev. 05/2022

YOUR PHOTOS & MULTIMEDIA

	Photos/Images may be used/posted:
☐ Photo received from you or personal representative	☐ In office
☐ Photo taken by staff (e.g., pre/post procedure)	☐ On office's website
☐ Other:______________________________	☐ Other: ____________________________

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

_______________________________________ _____________________

Patient/Personal Representative Signature **Date:** **mm/dd/yyyy**

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: ____________
mm/dd/yyyy

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: ____________________
mm/dd/yyyy

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes: ____

____

____

It is recommended that the practice review this form with the patient or their personal representative periodically for changes (e.g., annually with insurance verification).

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. This notice is posted at the front desk and a copy can be made for our patients upon request. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number (919) 467-0654.

Signature below is an acknowledgement that you have read and/or received a copy of this Notice of our Privacy Practices.

Patient/Guardian Signature________________________________ **Date**_____________

FINANCIAL POLICY

All of us at Drs. Wayne & Keith Beavers are happy to have you as a patient and we are excited about the future of our practice. We are committed to providing you with the highest quality dental care using only the best materials and technology available in the market today. We have invested a great deal of time and effort to update our software system to better serve our patients.

- We accept cash, check, Visa, MasterCard and Discover as payment. Payment is due at the time of service for all emergency care, nitrous oxide and cosmetic procedures.

- Insurance makes our life easier. If you have dental insurance, we expect you to pay your estimated share of the total fee at your visit. We will then file your insurance as a courtesy to you. Dental insurance rarely pays all the charges and you are always responsible for the full fee. The fees for services rendered are the usual and customary fees charged to all of our patients for similar services. Be aware that insurance coverage varies greatly between policies and your policy may base its allowance on a fee schedule that may not coincide with our fees. You must provide us with the necessary names, addresses and identification numbers along with proof of insurance eligibility if you would like us to bill your insurance company for you. If your insurance company does not remit payment within 60 days, the unpaid balance will be due from you. We may add a billing fee to all accounts 60 days past due.

- We are always willing to set up additional financial arrangements for our patients with treatment plans. These arrangements must be made with a financial coordinator prior to scheduling your treatment.

We value you as a patient of our practice. We hope that by informing you of our policies we can avoid any misunderstandings. If you have any questions about any of the financial options available, please feel free to discuss them with our dedicated staff members.

Patient/Guardian Signature________________________________ **Date**_____________