BEAVERS PEDIATRIC DENTISTRY

DR. NATHAN K. BEAVERS
DR. ANNE MARIE HREISH

PATIENT REGISTRATION FORM

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name_____ Preferrred Name_____ Age_____
Sex _____ Race_____ Date of Birth _____
Patient's Address_____ Home Phone _____
Street City State Zip
Father's Name _____ DOB _____ Social Security #_____
His Address _____ Phone _____
Street City State Zip
Where Employed _____ Phone _____
Mother's Name_____ DOB_____ Social Security #_____
Her Address_____ Phone _____
Street City State Zip
Where Employed _____ Phone _____
With whom does patient live_____
Other children in family who have received dental care in this office _____
Dental Insurance? Yes___ No___ Policy Holder_____ Company_____ ID Number_____
Child's Physician_____ Physician's Phone _____
Whom may we thank for referring you to our office _____
(Name)
E-mail Address_____

HEALTH HISTORY

	Yes	No
Is your child in good health? If no, please explain: _____		
Does your child have regular medical examinations?		
Is your child up to date with immunizations: If no, please explain: _____		
Is this your child's first dental visit? If no, Dentist: _____ Phone _____		
Date of your child's last dental care _____		
Is your child a thumb/finger sucker?		
Does your child use a pacifier?		
Was your child breastfed or bottle fed? ❑ Yes ❑ No And at what age was it discontinued? _____		
Is your child presently taking any medicine?_____ (Name of Medication)		
Has your child experienced any unfavorable reaction to medicine? (Such as penicillin, aspirin, xylocaine)		
Is your child allergic to any drug or food? If so, what?_____		
Is your child presently undergoing medical treatment?		
Has your child ever been hospitalized since birth?		
If so, Date:_____ Reason: _____		
Has your child ever had an unfavorable experience in a dental office:		
Purpose of this appointment _____		

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment:

_____

Check any of the following that may pertain to your child:

_____Rheumatic fever	_____Bleeding disorder	_____Lung problem	_____Mental disorder	_____Other:
_____Heart condition	_____Cerebral palsy	_____Brain injury	_____Emotional disorder	_____
_____Speech disorder	_____Liver	_____Epilepsy	_____Tuberculosis	_____
_____Hearing disorder	_____Kidney	_____Hepatitis	_____Sickle Cell Anemia	_____
_____Vision disorder	_____Asthma	_____Diabetes	_____Autism	_____
_____Nervous disorder	_____Allergies	_____HIV/AIDS		_____

AUTHORIZATION

Since _____ is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and /or all necessary dental service can be performed by Beavers Pediatric Dentistry. Authorization is hereby granted as such.

_____
Date Relationship Signed

Beavers Pediatric Dentistry

312 Fountains Dr. Madison, MS 39110 Phone: 601-856-5313

NOTICE OF PRIVACY PRACTICES

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 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, please contact us using the information listed at the beginning 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 providers providing treatment to you. PAYMENT: We may use and disclose your health information to obtain payment for services we provide 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. 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 the other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. PERSONS INVOLVED IN CARE: We may use or disclose your health information to notify or assist in the notification of 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 by law. **ABUSE OR NEGLECT:** We may use or 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. **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. **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 your health information. We are not required to agree to these additional restrictions but if we do we will abide by our agreement. ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternate means or locations. 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. We may deny your request under certain circumstances. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTIES 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:_____

Guardians 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, EMERGENCY SITUATION, OTHER. *If you need to obtain a copy of this notice of privacy practices, please contact our office*

Pediatric Dentists
Dr. Nathan K. Beavers D.M.D.
Dr. Anne Marie Hreish D.D.S.

Beavers Pediatric Dentistry
Financial Policy

Welcome to our practice. It is our policy to make definite financial arrangements with you before any treatment starts. Below is an explanation of our payment procedures.

1. **Patient portion of services is due at the time services are rendered.**
2. You must provide the office with a dental insurance card with the proper mailing address of the insurance company. If this is not available at the time of appointment, you will be responsible for payment of all fees.
3. We only file primary insurance. If your child has a secondary insurance, we will provide you with a copy of the charges for you to submit to the secondary insurance.
4. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.
5. Our office will file your insurance a maximum of **TWO** times per appointment. If the claim is not paid by your insurance carrier within **SIXTY** days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.
6. **For patients with all types of insurance coverage, the person who brings the child for their dental visit is responsible for payment. This also includes divorced parents. Reimbursement must be made between the divorced parents; Beavers Pediatric Dentistry will not intervene.**
7. After 90 days, we will inform you of the delinquent amount by letter and if no action is taken to clear the account, this office will be required to employ a collection service to collect payment. The responsible party agrees to pay all reasonable, related collection fees.

"I have read and accept the above Financial Policy and agree to the terms set forth."

"I agree to receive statements and communications through text message at the number I have provided."

Signature of Responsible Party: _____ Date: ___ / ___ / ___

NO SHOW/ CANCELLATION POLICY

Dr. Nathan K. Beavers and Dr. Anne Marie Hreish

Purpose: The Doctors and Staff of 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-hour notice or a no-show to an appointment are grounds for immediate dismissal from Beavers Pediatric Dentistry.
- Any unspecified patterns including, but not limited to: continually showing up late for appointments, continually cancelling appointments (even if given 24 hours' notice) will be grounds for 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 Beavers Pediatric Dentistry's policy. I will do everything 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 arrive late or without prior confirmation for scheduled appointments.**

_____

Patient Name

_____ _____

Parent/ Legal Guardian Signature Date