

Beasley Family & Implant Dentistry

www.beasleydentistry.com
appointments@beasleydentistry.com

Web - www.BeasleyDentistry.com | 200 East Hobbs St. • Athens, AL 35611

(256)233-1400

Date: _____

Chart#: _____

FOR OFFICE USE ONLY

Patient Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: _____ - - - - Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2

City State Zip Code

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

How were you referred to our office?

Emergency Contact name and phone number:

The following is for: the patient's spouse the person responsible for payment both neither-not applicable

Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: ____-____-____ DL#: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2

City State Zip Code

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Dental History

When was your last dental cleaning, exam and x-rays? Who was the providing dentist?

What is your present dental complaint?

MEDICAL HISTORY

Are you in good health? Yes No

If Applicable: Has there been any change in your health history since your last visit?

Please list your primary physician's name and phone number:

Are you under the care of a physician now? If so, for what conditions?

Date of your last physical examination:

Have you had any hospitalizations or surgeries within the past 5 years? If so, please list

Do you have any existing illnesses? If diabetic, list type I or II and last HbA1c reading:

Please list ANY medications or over the counter medicines or supplements that you are taking:

Please list your pharmacy and phone number:

Have you ever had rheumatic fever or had any artificial joint placed? If so, when?

Do you smoke / use tobacco? If so, # of cans / day or packs / day:

Do you currently use a CPAP for sleep apnea? Yes No

Do you or have you ever taken Zometa, Aredia, Boniva, Reclast, Fosamax, or Actonel? Yes No

Have you ever undergone treatment for drug or alcohol abuse? Yes No

Ladies: Are you pregnant, trying to get pregnant or think you may be pregnant? If yes, when is your due date?

Ladies: Are you currently taking birth control pills? If so please list?

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

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Abnormal bleeder | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Allergy - other _____ | <input type="checkbox"/> Allergy-Anesthetics |
| <input type="checkbox"/> Allergy-Other Drugs | <input type="checkbox"/> Allergy-Penicillin | <input type="checkbox"/> Antibiotic Pre-med | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> COVID-19 Vaccination |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Dementia | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> GERD | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Grapes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hay Fever/Sinus | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Stents |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Nursing Now | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pregnant Now | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Seizures | <input type="checkbox"/> Steroids | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Stomach ulcer/GERD | <input type="checkbox"/> Stroke | <input type="checkbox"/> TMJ | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Wasps | |

Please list any other drugs, food, or medications that you are allergic to:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health history and medication.

Signature _____ Date _____

Response Date: _____

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Please initial on each line below to indicate you have read and understand the following statements.

_____ *I authorize* the release of my dental records from Beasley Family & Implant Dentistry and/or individuals involved in my dental care. I further authorize the release of records from any individuals to Beasley Family & Implant Dentistry.

_____ *I authorize* insurance payments to be made directly to Beasley Family & Implant Dentistry. I understand I am responsible for any unpaid balance.

_____ *I am aware* that should I not provide adequate notice to change an appointment, I may be charged a fee. (48 hours, weekend cancellations do not provide 48 hours' notice).

_____ *I am aware* of and have received notice of the Health Insurance Portability and Accountability Act (HIPAA).

Notice of Privacy Practice – Acknowledgment

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by scheduling an appointment.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Authorization for Appointment Confirmation & Office Communications

As a courtesy to our patients, we often will give a variety of appointment reminders. Some of these reminders may generally include, but are not limited to, messages left with roommates/family members, voicemail messages, text messages, and emails. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's appointment time and date, or need for an appointment may be included.

By my signature below, I authorize Beasley Family & Implant Dentistry and staff to confirm my appointments and remind me of the need for an appointment in the above-mentioned ways, for the duration of my treatment with their office.

Authorization to Discuss Treatment & Financial Information

By my signature below, I authorize Beasley Family & Implant Dentistry and staff to discuss treatment with the people named below for the duration of my treatment with their office.

Name: _____ Relationship to Patient: _____ Cell Phone: _____

Name: _____ Relationship to Patient: _____ Cell Phone: _____

I do not authorize BFAID to discuss treatment with anyone other than myself.

Patient Name (PRINTED PLEASE) _____

Patient/Legal Custodian Signature: _____ **Date:** _____

BEASLEY DENTISTRY OFFICE POLICIES FOR PAYMENTS and INSURANCE:

* **Please initial next to each statement, showing that you understand and are aware of the following policies.**

- _____ When verifying benefits, it is never a guarantee of payment per your insurance company's disclaimer. You are responsible for **ALL** copays, deductibles, co-insurance amounts and non-covered services. All co-pays are due at the time of service. **YOU** are ultimately responsible for payment of all charges from our office.
- _____ It is **YOUR** responsibility to provide accurate insurance information and to present any updated insurance cards upon checking in for your appointment.
- _____ If your plan requires an insurance referral, it is your responsibility to obtain this prior to being seen.
- _____ It is our desire to help you as much as possible with claims that are submitted to your insurance company. If procedures are done in the office that are deemed non-covered by your insurance company, you will be responsible for payment.
- _____ We are contracted with the following insurance companies: BCBS of AL, Delta Dental (Premier Plan), Southland National, Guardian, Aetna, Principal, Ameritas, Cigna Healthsprings, Anthem BCBS and some United Concordia plans. If we are not in network we will be happy to file your insurance. Please be aware that you will be financially responsible for the difference between our fees and what your insurance company pays.
- _____ For our patients without insurance please understand that full payment is due the day treatment is rendered. We gladly accept cash, personal checks, Carecredit and all major credit cards. Also, please ask us about financing options.
- _____ The long term success of dental treatment we provide for you depends on your in home and in office dental care. Failure to maintain good home care and minimum 6 month cleanings and exams in our office will void your dental warranty.
- _____ All unpaid previous balances must be paid in full prior to making any additional appointments, unless arrangements have been made with the billing office
- _____ Our RETURNED CHECK fee is \$ 30.00
- _____ Once your account becomes 30 days or more delinquent with no attempt to make payments by you, your account may be turned over to collections. You agree to reimburse our office for the fees of any collection agency, which will be based on an interest rate of up to 8% annually, an initial flat fee of \$10.95 when turned over to the collection agency and an additional fee of 21% of the overdue balance should the balance not be paid within the first 60 days from the date of submission to the agency or if your account is submitted directly to the intensive collection efforts of the agency. You also agree to pay all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts.

BEASLEY DENTISTRY OFFICE POLICIES FOR CANCELLATIONS and NO-SHOWS:

- _____ When an appointment is scheduled, that time has been set aside for you and cannot be used to treat another patient. Cancellations for appointments must be received 48 hours prior to the scheduled appointment.
- _____ Patients who fail to keep scheduled appointments will be charged a \$45 no-show/late cancellation fee. Continued no-shows will require a \$45 deposit or more prior to another appointment being made.
- _____ Scheduling of any major procedure requires payment of a deposit to schedule your appointment. This deposit will be due approximately 1 week prior to your appointment and the deposit amount is applied to your bill. If you fail to keep your reserved appointment this deposit amount is forfeited. Your appointment will **NOT** be confirmed until this deposit is made and in such case the appointment time will be given to another patient.

Patient Signature: _____ **Date:** _____

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F: 256.573.1466

200 E Hobbs St
Athens, AL 35611

Dr. Robert B. Beasley, DMD

Credit Card Authorization Form

In an effort to better serve you, we ask that you take care of the fees for your visit at the time of service. Depending upon the procedure, we may ask for a 25% deposit ahead of your appointment to confirm it. By allowing us credit card authorization, you are giving us permission to keep your card on file and charge any balance due on the date of service and/or a balance which is past due by 30 days. **You will be contacted by the office if any charges or credits will be applied to your credit card.**

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip Code: _____

Credit Card Details:

Card Type: Visa MasterCard American Express Discover Other: _____

Cardholder Name: _____

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____

Consent: (Check one of the following)

____ I, the undersigned cardholder, **DO** authorize the merchant known as Beasley Family & Implant Dentistry to charge my credit card for purchases related to goods and services. I agree that my information will be saved by the merchant for future payments and understand that this can be revoked at any time with request.

____ I, the undersigned cardholder, **DO NOT** authorize the merchant known as Beasley Family & Implant Dentistry to collect my credit card information for future purchases related to goods and services. I understand that any outstanding balances will collect a 2% per month finance charge on my balance if not paid within 30 days of charge.

Cardholder's Signature: _____ Date: _____