Beaver Dental Care

Zan Beaver, DMD

WELCOME TO OUR PRACTICE

On behalf of the entire team at Beaver Dental Care, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Personal Information Sheet and Medical and Dental History questionnaire that should be filled out prior to your first appointment with us.

Be sure to visit our website at www.BeaverDental.com. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Zan Beaver, DMD

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1677 Art Museum Drive • Jacksonville, FL 32207 • (904) 201-3571

www.BeaverDental.com

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Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form. All of this information is completely confidential.

PATIENT INFORMATION

M F S M D W

Name (Last) (First) (Middle) Date of Birth Sex Marital Status Social Security Number

Preferred Name Email Address Cell Phone Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

Name of Employer Occupation

Business Address (Street) (City) (State) (ZIP Code) Business Phone Number

Emergency Contact Phone Number

Spouse's Name

Spouse's Employer Occupation

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Who is responsible for account? ❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other

Please fill in the following information if the person responsible is different from self.

Relation to patient: _____

Name (Last) (First) (Middle) Date of Birth Social Security Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

Name of Employer Occupation Business Phone Number

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DENTAL INSURANCE INFORMATION

Is patient covered by dental insurance? ❑ Yes ❑ No

If yes, please complete the following:

Policy Holder Name (Last) (First) (Middle) Date of Birth Social Security Number

Name of Employer Occupation Business Phone Number

Business Address (Street) (City) (State) (ZIP Code) Dental Insurance Co.

Group # _____ Subscriber ID # _____

Is patient covered by additional dental insurance? ❑ Yes ❑ No

If yes, please complete the following:

Policy Holder Name (Last) (First) (Middle) Date of Birth Social Security Number

Name of Employer Occupation Business Phone Number

Business Address (Street) (City) (State) (ZIP Code) Dental Insurance Co.

Group # _____ Subscriber ID # _____

INSURANCE AUTHORIZATION & FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible for all charges whether or not paid by insurance. I assign all insurance benefits directly to the doctor otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature (Parent/Guardian if under age 18) Relationship (if patient is under age 18) Date

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MEDICAL HISTORY

Patient Name: _____

Physician's Name: _____ Phone: _____ Date of Last Visit: _____

Please check the box if you have ever had any of the following:

❏ AIDS or HIV positive
❏ Acid Reflux or G.E.R.D
❏ Arthritis (Supply Type in "Details" Below)
❏ Artificial joints
❏ Asthma
❏ Cancer
❏ Chemical dependency
❏ Diabetes (Supply Type in "Details" Below)
❏ Eating disorder
❏ Epilepsy
❏ Excessive bleeding
❏ Glaucoma
❏ Hepatitis (Supply Type in "Details" Below)
❏ Kidney problems
❏ Liver problems or jaundice
❏ Lung or breathing problems
❏ Sinus trouble
❏ Smoking or chewing tobacco
❏ Stroke
❏ Swollen neck glands
❏ Thyroid problems
❏ Tuberculosis

Give details and location of the above checked items: _____

_____

Heart Problems

❏ Low blood pressure
❏ High blood pressure
❏ Pacemaker
❏ Artificial valves
❏ Infective (bacterial) endocarditis
❏ Congenital heart defects
❏ Heart surgeries
❏ Other _____

Allergies

❏ Aspirin
❏ Codeine
❏ Latex
❏ Local anesthetic
❏ Penicillin
❏ Sulfa
❏ Other _____

❏ Antibiotics for dental treatment
❏ Currently under a physician's care
❏ Serious illnesses/hospitalizations

Medications

Please list medications you are currently taking and why.

_____

_____

Women

Are you pregnant? ❏ Yes ❏ No If yes, expected delivery date: _____

Are you nursing? ❏ Yes ❏ No Are you taking birth control pills? ❏ Yes ❏ No

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DENTAL HISTORY (NEW PATIENTS ONLY)

Please check the box if you have ever had any of the following:

❑ Bad breath problem
❑ Frequent headaches, neck aches
❑ TMJ, jaw joint pain or treatment
❑ Gum disease treatment
❑ Canker sores in mouth
❑ Cold sores on outer lips
❑ Dental anesthetic problems
❑ Orthodontics (braces)
❑ Full dentures or partial dentures
❑ Biteguard or nightguard
❑ Oral surgery
❑ Excessive gag reflex
❑ Fear of dental care

Please check the box if you currently have any of the following:

❑ Pain
❑ Sensitivity to - heat - cold - biting
❑ Dry mouth
❑ Food packing between teeth
❑ Pain around ear
❑ Toothache
❑ Sensitivity to - sweets - pressure
❑ Mouth breathing
❑ Clicking or popping jaw
❑ Vague ache
❑ Broken tooth or filling
❑ Sores or growths in mouth
❑ Clenching or grinding of teeth
❑ Swelling
❑ Loose tooth
❑ Bleeding gums
❑ Tired, sore or painful jaw joint

Other: _____

Give details and location of the above checked items: _____

_____

How often do you brush? _____ How often do you floss? _____

What type toothbrush do you use? ❑ Ultrasoft ❑ Soft ❑ Medium ❑ Hard ❑ Electric

Reason for today's visit: _____

Former Dentist: _____ City/State: _____ Phone: _____

Date and reason of last dental visit: _____

Date of last dental X-rays: _____

What have you liked about any dental office you've been to? _____

What have you liked LEAST about any dental office you've been to? _____

TREATMENT AUTHORIZATION

I have reviewed the information on this form and it is accurate to the best of my knowledge. I authorize and give consent for the dentist and/or team of this office to perform dental services as agreed between doctor and patient and/or guardian, including the use of local anesthetic and other medication as indicated.

_____

Signature (Parent/Guardian if under age 18) Relationship (if patient is under age 18) Date

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Beaver Dental Care
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Beaver Dental Care, hereafter referred to as "Practice," is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information, hereafter referred to as "PHI," to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 45 CFR§ 164.520. This Notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 01/25/13. This notice replaces previous versions of the Notice and is effective 3/12/2014. You may access or obtain a copy according to the following options: 1) our website at www.BeaverDental.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

1. USES & DISCLOSURES OF PHI. How We Use Your Information: Your PHI may be used and disclosed by our Practice's provider, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you.
A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist.
B) Payment: We will use your PHI to obtain payment for the services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided.
C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff.
D) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement with business associates to assure the protection and privacy of your PHI

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:
E) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:
i) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.
ii) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.
iii) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclosure such information as necessary if we determine that it is in your best

interest based on our professional judgment. If a young adult age eighteen (18) requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement.

iv) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you:

A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.

B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include patient and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details).

C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice.

D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.

E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.

F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the EHR. To request an accounting, submit your request in writing to the Privacy Officer.

G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.

H) Fundraising: If PHI is used for fundraising which is considered "health care operations," basic requirements must be satisfied to include notice to you and a process for you to opt-out. If the individual consents, only specific parts of PHI may be used for fundraising. Note: Your PHI will not be used in this manner.

3. COMPLAINTS. You have the right to file a complaint if you believe your privacy rights or that of another individuals' have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days of when you knew that the act occurred. Visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

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Jacksonville, Florida 32207
TEL: (904) 201-3571
FAX: (904) 396-4924

You will not be penalized for filing a complaint.