# Welcome to
# Beaver Dental Care

**Patient information**

Name: _____ DOB: _____ SS#: _____
Last First M.I

Address: _____ City: _____ State/Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____

Sex: M/ F Status: Married Single Separated Divorced Widowed

Emergency Contact: _____ Contact #: _____

Whom may we thank for referring you? _____

**Insurance Information**

Policy Holder: _____ Relation: _____
Last First M.I
Employer: _____ Occupation: _____

DOB: _____ SS#: _____ Employer: _____

Insurance Company: _____ Phone #: _____

**Dental History**

How often do you: Brush? _____ Floss? _____
How do you feel about the appearance of your teeth? _____

Reason for today's visit: (circle ALL that apply)

| | | |
|---|---|---|
| Bad Breath | Food collection in teeth | Periodontal treatment |
| Sensitivity to sweets | Grinding/Clinching teeth | Bleeding gums |
| Sensitivity to cold | Sensitivity to hot | Loose teeth or broken fillings |
| Sensitivity when biting | Clicking/Popping jaw | Sores or growths in mouth |

**Medical History**

Are you currently under physician care? _____ yes _____ no

Physician's name: _____ Contact #: _____

Have you ever had a blood transfusion? _____ yes _____ no

Have you ever taken Fen-Phen/Redux? _____ yes _____ no

**WOMEN ONLY: (are you)** _____Pregnant _____Nursing _____Taking birth control

**Do you currently/have you ever had any of the following: (circle ALL that apply)**

| | | | | | |
|---|---|---|---|---|---|
| Aids/HIV | Diabetes | Fainting | Hepatitis | Radiation/Chemotherapy | Swelling of feet/ankles |
| Anaphylaxis | Chemical Dependency | Glaucoma | High Blood Pressure | Respiratory Disease | Thyroid Issues |
| Anemia | Cancer | Headaches | Kidney Disease | Rheumatic Fever | Tobacco Habit |
| Arthritis | Circulatory Problems | Heart Murmur | Liver Disease | Shingles | Tonsillitis |
| Artificial Heart Valves | Cortisone Treatments | Heart Problems | Mitral Valve Prolapse | Shortness of breath | Tuberculosis |
| Artificial joints | Persistent Cough | Heart Attack | Nervous Disorder | Skin Rash | Ulcer/Colitis |
| Asthma | Hemophilia | Pacemaker | Stroke | Venereal Disease | Blood Disease |
| Epilepsy | Herpes | Psychiatric Care | Surgical Implant | | |

Please list **ALL** medications that you are currently taking:

_____

_____

Please list **ALL** drug, food, and material allergies:

_____

_____

Authorization I have reviewed ALL information on this medical history, and it is accurate to the best of my knowledge. I understand that this information will be used by my dentist to help determine appropriate and healthful dental treatment. If there are any changes, I will inform my dentist promptly.

Signature: _____ Date: _____

**Dr. Reviewed Medical Hx: _____ Date: _____

BEAVER
DENTAL CARE

*1677 Art Museum Drive, Jacksonville, Florida 32207 - (904) 396-4746*

We understand that choosing a new dentist and dental health team can be a challenge, leaving you feeling somewhat uncertain. Let us welcome you and share some insights about what we do for our patients. The philosophy guiding our practice is as follows:

***"Our purpose is to help people achieve the highest level of well-being appropriate for them and, in so doing, to enhance the quality of their lives."***

In other words, we help you be or become as healthy as you choose. This is a major departure from the way we were trained. Instead of telling you how healthy you ought to be, we will try to help you understand your choices about dental health and then you make a free and informed decision. Your first choice in this regard is how you would like to begin with us. There are five levels on which people may choose to be seen in our practice**. Please circle the level of care you feel most appropriate for you at this time.**

Level 1: **URGENT CARE** People in crisis or with an emergency problem such as pain, swelling or bleeding that need immediate help are at this level. Generally people at this level only desire emergency treatment.

Level 2: **REMEDIAL CARE** People who choose this level of care desire treatment only when something breaks or becomes uncomfortable. Generally people at this level expect a limited type of examination focusing on the obvious problems. They usually want to correct immediate problems with as little effort and cost as possible.

Level 3: **SELF-CARE** Patients who choose this level of care want a thorough examination and take an active part in the treatment and prevention of present and future disease problems. However, they usually choose repair solutions that are short range in nature.

Level 4: **COMPLETE DENTISTRY** Patients at this level are similar to people described in level 3. They choose to have a thorough examination. However, they decide on a **MASTER PLAN** to formulate a long-term treatment plan for health and repair. These patients are very concerned about treating the causes of dental disease, not simply the effects. These patients want all dental treatment provided to be completed in the most lasting fashion possible.

Level 5: **LOOK YOUR BEST** People in this group are in level 4 as far as dental health is concerned, but also want to look their best at all times. They know that their smile is one of the first things others notice about them.

We hope these levels of care make sense to you. It is not uncommon for people to begin at one level and progress to another over time. We are here to help you discover and decide at what level you are most comfortable. Thank you for the opportunity to serve and provide you with the best dentistry for you.

To **YOUR** health,

Dr. H.A. Beaver


*1677 Art Museum Drive, Jacksonville, Florida 32207 - (904) 396-4746*

# Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Further, I understand that I am entering into a contractual relationship with H.A. Beaver, III, DMD for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a dental provider. As additional consideration for professional care provided to me by H.A. Beaver, III, DMD, I, agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against H.A. Beaver, III, DMD.

Furthermore, should a dental malpractice case or cause of action be initiated or pursued, I agree to use expert witness (es) who practice primarily in the same specialty as H.A. Beaver, III, DMD. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and / or code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this, H.A. Beaver, III, DMD agrees to the same stipulations.

I acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Doctor's reputation and business. Both H.A. Beaver, III, DMD and I agree in the event of a breach to allow specific performance and/or injunctive relief.

As with all healthcare treatment, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling and discomfort after treatment
2. Infection in need of medication, follow-up procedures or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste
4. Damage to adjacent teeth, restorations or gums
5. Possible deterioration of your condition which may result in tooth loss
6. The need for replacement of restorations, implants or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist
9. A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop
10. Jaw fracture
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

_____ _____

Patient Date Witness Date

_____ _____

Print Patient Name Parent/Legal Guardian Date

.

# FINANCIAL POLICY

We the staff of Beaver Dental Care thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are doing everything possible to contain the cost of dental care and you can help a great deal by eliminating the need for us to bill you.

The following is a summary of our financial policy.
ALL PAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor assignment of insurance benefits, payment for services will be due at time of service unless a payment arrangement has been approved in advance by our staff.

_____ **PAYMENTS**

We make payment as convenient as possible by accepting cash, money order, ALL major credit cards, and in-state checks. Please know that a $35.00 service fee WILL be charged for all returned checks.

_____ **INTEREST/COLLECTIONS**

We reserve the right to charge interest on any unpaid balance. Please note that if a balance remains unpaid for more than 60 days, interest will occur from that point and until the balance is paid in full. In addition, if it becomes necessary to forward your account to a collection agency, please be aware that you will then be responsible for the amount owed plus any fees charged by the agency for the cost of collections.

_____ **INSURANCE**

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your plan. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to play an active role and to be responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance information (this includes a photo ID) and to notify our office with any changes to this information if and when they occur. It is also your responsibility to know if our office is a participating or NON-participating provider with your insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier. **PRE-AUTHORIZATION of services does NOT guarantee payment from insurance carrier** Please be aware the out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or restrictions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal, if these limitations are imposed, you as the guarantor are responsible for ALL out-of-network fees. If we are not contracted with your carrier we will NOT negotiate reduced fees with them.

_____ **MISSED APPOINTMENTS/LATE APPOINTMENTS/CANCELLATIONS**

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time that was set aside for you.
We require a 24 hour notice when cancelling or rescheduling an appointment. Failure to do so may result in a $45.00 broken appointment fee. Also, if you arrive 15 minutes or more past your scheduled appointment, your appointment will be re-scheduled upon arrival so that other scheduled patients who arrive at their appointed times are not affected. We understand that emergencies happen and we are willing to work with you however, please be courteous of our time as well as other patients in the practice.

I have read, understand, and initialed each area of the Beaver Dental Care Financial Policy.

_____ _____ _____

Printed Name Signature of Patient Date


*Your privacy is important to us*

**Acknowledgement of Receipt of Notice of Privacy Policies**

I have received a copy of the Notice of Privacy Practices of Beaver Dental Care. I hereby authorize, as indicated by my signature below, Beaver Dental Care to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

- You may contact me at my home telephone number _____
- You may contact me on my mobile telephone number _____
- You may contact me on my work telephone number _____
- You may send me an unencrypted email/text message _____
- Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added/ Removed _____
2. _____Date Added/ Removed _____
3. _____Date Added/ Removed _____
4. _____Date Added/ Removed _____

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 prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please specify) _____

  Staff Person Initials _____

# 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:

Beaver Dental Care
1677 Art Museum Drive
Jacksonville, Florida 32207
TEL: (904) 201-3571
FAX: (904) 396-4924

You will not be penalized for filing a complaint.