# ***Dr. David R. Beckman, D.D.S., Inc.***

## Patient Information:

**Thank your for choosing our practice for your dental needs. Please complete the **FRONT AND BACK** of this form in ink. If you have any questions or concerns do not hesitate to ask for assistance. We will be happy to help. **

**- Please Print –**

**Name_____Date_____ SS#_____**
First Middle Initial Last

**Address_____ City_____ State_____ ZiP_____**

**Sex: M F Birthday_____ E-Mail _____**

**Home Phone (___) _____Cell Phone (___) _____Work Phone (___) _____**

Do you prefer to receive calls at: Home Cell Work

**Are you: Married Widowed Single Separated Divorced**

**Patient Employer/School _____ Occupation _____**

**Employer/School Address_____City_____State_____Zip_____**

**Person to contact in case of Emergency_____ Phone (___) _____**

**How did you find our practice? _____**

## ● Responsible Party:

**Name of person responsible for this account_____**

**Relationship to patient_____ Phone (___) _____**

**Address_____ City_____ State_____ Zip_____**

**Name of employer_____ Phone (___) _____**

*Insurance: To avoid any misunderstanding regarding dental insurance, it is our office policy to let our patients know that all professional services rendered are charged directly to the patient and that patients are responsible for payment of fees. We will prepare necessary forms and reports to help you obtain benefits from Insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that Insurance companies will pay all our fees. Each fee is individual for the individual patient. If you are covered by a Pre-paid dental plan, **co-payment must be made when treatment is rendered.***

**Signature_____ Date _____**

## ● Dental History:

**Name_____ Age_____ Reason for today's visit_____**

**Date of last exam and/ dental X- rays_____ Former Dentist_____**

**How often do you brush? _____How often do you floss_____**

**Please CHECK any of the following that apply to you:**

| | | |
|---|---|---|
| __Bad breath | __Grinding teeth | __Sensitivity to heat |
| __Bleeding gums | __ loose teeth or fillings | __Sensitivity to sweets |
| __Clicking or popping jaw | __Periodontal treatment | __Sensitivity when biting |
| __Food collection between teeth | __Sensitivity to cold | __ Sores or growth's in mouth |

## ● Certification & Assignment

*To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I or my children ever have a change in health.*

**I certify that I. and/or my dependent(s) have insurance coverage with_____
And assign directly to Dr._____ all insurance benefits if any. Otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. *The above-name doctor may use my health care information man may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the dated signed below. **

_____ _____
**Print name - Patient, Parent, Guardian or Personal Representative** **Date**

_____ _____
**Signature of Patient, Parent, Guardian or Personal Representative** **Relationship to Patient**

# Medical History

The oral cavity is the window to the body. Many health problems that exist can present first in the mouth. In order to better serve our patients we ask you to provide a complete health history picture. Nothing is trivial. If you do not see something listed below, or is experiencing symptoms please list or describe them in the space provided at the bottom of the page. Remember you history is confidential (See HIPPA form)

## Medications:

**Please provide a complete list of medications you are taking. This should include Name, Dose and when you take the medication. If you don't know the name, simply write why you are taking a particular medication.**

_____

_____

_____

_____

**Are you taking any of the fallowing Herbal remedies?**
****PLEASE CIRCLE****
**Ginkgo , Garlic , Danshen , Dong quai , St Johns wort , Chaparral , Coltsfoot , Comfrey , Germander , Licorice , Feverfew , Valerian , Kava , Ginseng.**

**Certain medications in combination with local anesthetics can cause cardiovascular toxicity.**

***Are you taking any of the fallowing?**
**Ephedra, Cocaine, and/or any other dietary drugs. YES NO**

**Allergies: If you are allergic to any of the following?**
****PLEASE CIRCLE****

**Latex, Penicillin, Sulfa drugs, Amoxicillin, Erythromycin, Tetracycline, Aspirin, Codeine, Dental Anesthetics.**

***Are you allergic to any cosmetic products or any other product?**
**(PLEASE LIST)**

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* **Do you use hypoallergenic sunscreens or cosmetics? YES NO**
* **Do you use tobacco products? YES NO Amount_____ How long_____**
* **Do you use contact lens? YES NO**
* **Rate you general health 1- 10 _____**
**women* - **Are you on birth control? YES NO How long_____**
* **Are you pregnant? YES NO**
If "yes" are you **presently nursing How long_____**

* **Do you have *or* have you had any of the following diseases, medical conditions or procedures?**
****PLEASE CIRCLE****

| | | | |
|---|---|---|---|
| Heart attack / Stroke | Thyroid Problems | Cancer / Tumors | Cosmetic Surgery |
| Heart Surgery | Kidney Problems | Shingles | X-ray or Cobalt Treatment |
| Heart Murmur | liver problems | Hepatitis | Chemotherapy |
| Rheumatic Fever | Respiratory Problems | HIV / AIDS | Asthma |
| Mitral valve prolapsed | Sinus Problems | Artificial Bones / Joints | Diabetes / Hypoglycemia |
| Artificial Valves | Stomach Problems | Arthritis / Rheumatism | Difficulty Breathing |
| Heart Disease | Psychiatric Problems | Emphysema | Leukemia |
| Congenital Heart Defect | Venereal Disease | Seizures / Epilepsy | Anemia |
| Chest pains | Alcohol / Drug abuse | Frequent Headaches | High / low Blood pressure |
| Scarlet Fever | Tuberculosis TB | Frequent Neck Pain | Bleeding Problems |
| Nervousness | Jaw Problems TMJ / TMD | Back Problems | Glaucoma |

**Please list any other medical condition / problem or procedure since your last visit**

_____
_____
_____
_____

# Family practice

## Privacy Consent- For the use and Disclosure of Protected Health Information

**This consent is required by Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.**

**I hereby give my consent to Dr. David R Beckman use and disclose my protected health information for the purpose of treatment, payment, and operations of my health care and the practice.**

**Consent for treatment:**
I, with my signature, authorize this family Practitioner and any employee working under the direction of this physician, to provide medical care for me, or to this patient for which I am legal guardian. This medical care may include assessment of my condition, management, treatment, and supportive care and services related to my needs and conditions. This may include (but not limited to ) evaluation of medical condition, medical management, procedures, diagnostic testing, therapeutic care, coordination of care with surgeon, hospital employees, and other medical specialists, home health care, counseling, the prescribing of drugs or other services required for you care. This may include photographs and other images to help with treatment planning at outcome assessment. This consent includes contact and discussion with other health care professionals, specialists, hospital personal, and therapists for your care and treatment.

**Consent related to the Privacy Notice:**
I have had a chance to review and Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone and writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on (PHI) use, it is bound by that agreement.

- **I understand that this practice may refuse my services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.**

**Signature _____ Date _____**

## Dr. David R. Beckman D.D.S., Inc.

## FINANCIAL POLICY

**Dear Patient:**

**In an effort to reduce costs, increase efficiency and maintain a higher level of professional care, we have created a financial policy that both patients and office personnel must adhere to.**

**- Our Office Policy is as follows:**

**1. We accept payments by CASH, CHECK, VISA, MASTERCARD and DISCOVER.**

**2. As a courtesy, we will accept most insurance, and will gladly process your claim, however any estimated deductibles, and co-payments will be due in full at time of visit.**
**Patient initials x _____**

**3. Although our office will process your insurance claims please understand it is your responsibility to satisfy any account balance in full for all services rendered.**
**Patient initials x _____**

**4. We require a 24 hour notice for all cancellations. A fee will be assessed if proper notice is not received at $ 88.00 per scheduled hour.**

**Patient initials x_____**

*** If you have any questions regarding these financial policies, please do not hesitate to speak to our office personnel. We are here to help you in every possible way.**

**PLEASE ACKNOWLEDGE THAT YOU UNDERSTAND THE ABOVE POLICIES**

**Patient or Responsible party _____ Date _____**
**Financial Coordinator _____**

**Dr. David R. Beckman D.D.S., Inc.**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You may refuse to sign this Acknowledgement***

**I, _____, have received a copy of this office's Notice of Privacy Practices.**

_____
**(Print Name)**

_____
**(Signature)**

_____
**(Date)**

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**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**
- **Communications barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (please specify)**

_____

_____

# Practice Privacy Statement

**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.**

This is a formal notification, as required by the government concerning the privacy policy of this practice. This practice has an obligation to maintain all medical information in the strictest of confidence. Our practice cannot release information without your written consent, including medical records, conversations, reminder calls, test results and other confidential issues. Patient information about health care is identified as "PHI" or protected health information. You can change this information at any time with either written notification or verbal notification, followed up in writing. Changes can only impact the care or information for that point in time.

- **Your protected health information (PHI) is part of your medical care, and can be used or disclosed as follows:**
- **For your treatment in this practice and other locations under our immediate care for care needs. This may include any medical assessment, diagnostic testing, treatment and procedures related to your needs. This may include coordination with others (Surgeon, Radiology, and Specialists) for your care, referral for services, diagnostic tests or treatment related to your medical care needs. This may also include discussions with home care agencies, Hospice, spiritual support, counselors, and others should you need these services during the course of your care.**
- **For obtaining payment for treatment with your identified health care program. This would include any documentation related to this care, including history forms, progress notes, pictures and/or video tape and procedure notes. This would include eligibility verification, prior authorization and claim submission.**
- **For operations of this practice, such as enrolling with insurance programs. Hospital privileges, Quality Care Programs and compliance with federal and state laws and regulations:**
- **Appointment reminders and health related benefit services only with your consent identified on the registration form.**
- **Disclosure to your family and friends concerning any related health care information given on the registration form, which can be modified at any time orally, followed by written consent.**
- **Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.**

**<u>Certain disclosures can be made without your consent, and they are as follows:</u>**

- **Disclosure required by the government or law enforcement agencies. An example would be victims of abuse.**
- **Information used for public health purpose, medical examiners and related to a person's death or for the health department for disease tracking. This would include information to a funeral director after death concerning any artificial devices you may have in your body. Information is only released to executors of estates in most cases.**
- **Information used for health care oversight, such as a site reviewed by an insurance program.**

**<u>Your rights for your health information include:</u>**

- **The right to request limits on the use and disclosure at registration or any time during you care.**
- **The right to choose how we sent this information to you, including an alternate address.**
- **The right to see and obtain copies of you PHI, but there may be copy and postage fees.**
- **The right to get a listing of who we have made disclosures to about your PHI. The right to correct your file through an amendment process if appropriate.**
- **This practice reserves the right to modify or change the privacy statement and process at any time. Revision to the notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the privacy notice.**
- **An updated privacy notice will be posted in the office within 60 days of the revision.**

*If you have a concern or complaint about how your protected health information is being used, you should first contact your Practice Administrator in your Business Office to resolve your concerns, or you may contact the Office of Civil Rights or the Ohio Medicare Carrier GBA Palmetto.*

**Office of Civil Rights- Regional Manager**
**Dept. of Health & Human Services**
**233 N. Michigan Avenue, Suite 240**

**Palmetto GPA**
**Part B Operations- HIPPA Compliance Concerns**
**P.O. Box 18957**

## OUR FINANCIAL POLICY

**Our office does accept CASH, CHECKS, MONEY ORDERS, VISA, MASTERCARD and DISCOVER. ALL FEES, co-payments are due day of service. Fees for major work such as crowns, bridges, dentures and implants need to be satisfied before the placement appointment. If you cannot do so, arrangements need to be made in advance at the front desk. Our office does offer payment plans for certain procedures. Our policy is at least 50% down and remaining 50% in equal payments over the next three to six months. A payment plan will be set up according to your Treatment Plan. Payment booklets can be provided. We will not change interest during agreed payment plan time period; however any balance remaining will incur an interest rate of 18% APR (Annual percentage rate).**

## TREATMENT PLANS

**After examination or consultation you will receive a written plan for your dental treatment. This treatment plan will inform you of all the treatment and options discussed with your clinicians and gives you a specific breakdown of costs and insurance benefits if any. Emergency appointments will receive limited treatment plans and must not be construed as a comprehensive treatment plan.**

## DENTAL INSURANCE

**Our office will gladly file an appropriate insurance document for any procedure we perform. Unfortunately, the insurance companies have an adversarial relationship with dentists. The insurance companies are in the business to make money and sometimes this will be reflected by their reluctance to process a properly completed claim. We will re-submit an insurance claim up to three separate times in order to fulfill the insurance companies' needs. However, after three attempts we must ask our patients or someone from their employer's personnel department to call to expedite the processing of their claim. Also, at that time you will be responsible to make arrangements to pay the balance. We will continue to work on your behalf to obtain benefits and resolution of that benefit will be paid back to you. Remember, the relationship is between you and the insurance company, and they can decline to work with us. Any balance remaining is still the patient's responsibility.**

## "IN HOUSE" DENTAL INSURANCE

**Certain patients without dental insurance can benefit from Dr. Beckman's Plan. For a nominal yearly fee, individuals and families can receive free checkups and save 30-50 % on most dental procedures. Inquire with the front desk on whether Dr. Beckman's Plan would benefit you.**

## CANCELLATION POLICY

**Our office recognizes that your time is valuable. We make every effort to see you at your scheduled appointment time. Emergencies occur and if we are behind we will notify you so that your schedule is not adversely affected. While we are still accepting new patents, our "chair-time" is at a premium. If you cannot make a scheduled appointment we ask that you give a 48hr. notice for non- emergency situation. Often with proper notice we can give your time to a patient that needs to be seen for emergency care. Cancellations without notice will be subject to an $88.00 per scheduled hour fee.**