LITTLETON DENTAL STUDIO

DR. CALE BEASLEY, DDS
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Today's Date ____/____/_____

Welcome! Patient Information

Name _____ Preferred Name _____

Birth Date _____ Age _____ SS# _____

Home Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Driver's License # _____

Cell Phone _____ Email _____

Employer _____ Address _____

How Long Employed _____ Occupation _____

Parent or Guardian (if under 18 years of age) _____

Contact in Case of Emergency _____ Relationship _____

Address _____ Phone _____

Who referred you to our office? _____

Medical History

It is important that I know your Medical and Dental history. These facts have a direct bearing on your Dental Health. This information is protected under HIPPA regulations.

Are you currently under physician's care? Yes ❑ / No ❑

If Yes, why? _____

Are you pregnant? Yes ❑ / No ❑

If Yes, why? _____

What medications are you currently taking?

_____

Family Physician _____

Phone Number _____

Office Use Only:

_____

_____

_____

_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

Heart Disease or Attack	AIDS/ARC/HIV Pos.	Bruise Easily
Angina Pactoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Hepatitis C	Asthma
Rheumatic Fever	Liver Disease	Hay Fever
Congenital Heart Lesions	Blood Transfusion	Sinus Trouble
Mitral Valve Prolapse	Drug Addiction	Allergies or Hives
Artificial Heart Valve	Hemophilia (Bleeding Problems)	Diabetes
Heart Pacemaker	Fever Blister	Thyroid Disease
Heart Surgery	Epilepsy or Seizures	Radiation Treatment
Artificial Joints (Hip, Knee)	Nervousness	Arthritis
Anemia	Psychiatric Treatment	Cortisone Medicine
Stroke	Glaucoma	Pain in Jaw Joints
Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Alcoholism
Ulcers	Venereal Disease (Syphilis, Gonorrhea, etc.)	Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?

Aspirin	Local Anesthetic	Erythromycin	Latex (balloons,
Nitrous Oxide	Codeine	Penicillin	gloves, etc.)

Are you aware of allergies to any other medications or substances? Yes ❑ / No ❑

If Yes, please list _____

Is there any other Medical or Dental information that you feel I should know about?

_____

_____

CONTINUED ON REVERSE

Dental History

Why have you come to see the dentist today? _____

_____

_____

Are any of your teeth sensitive to:

Heat	Yes ❑ / No ❑	Cold	Yes ❑ / No ❑
Biting Pressure	Yes ❑ / No ❑	Sweets	Yes ❑ / No ❑

Are you currently experiencing any dental pain? Yes ❑ / No ❑

Does food catch in your teeth? Yes ❑ / No ❑

Have you ever had any teeth extracted? Yes ❑ / No ❑

Do your gums bleed when brushing or flossing? Yes ❑ / No ❑

Do you like the appearance of your teeth? Yes ❑ / No ❑

Would you like to have whiter teeth? Yes ❑ / No ❑

Do you feel you may someday wear dentures? Yes ❑ / No ❑

Does your jaw joint bother you? Yes ❑ / No ❑

When did you last see a dentist? _____

Why did you leave your last dentist? _____

Please rank the order in which these concerns would keep you from dental treatment; 1=Most Likely, 4=Least Likely:

Fear of Pain_____ Lack of Concern_____ Cost of Treatment_____ Missing Work Time_____

Primary Dental Insurance

Insured's Name _____ Birth Date _____ SS# _____

Employer _____ Group Plan Policy # _____

Insurance Co. _____ Phone _____

Insurance Co. Address _____

_____

THE INFORMATION I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I MUST INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

The undersigned hereby authorizes the Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor in order to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all form of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or returned to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Patient's Signature _____ Date _____ Witness _____

(or that of Parent/Guardian of Minor)

Littleton Dental Studio Missed Appointment Agreement

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or late canceling an appointment means we are unable to fill this appointment time with another patient who desperately needs care. Additionally, as an individually owned small business, we are unable to recoup lost compensation for our service, which is what keeps our doors open and pays our staff.

Our policy requires:

- Appointment conformation: You must call or text to confirm your appointment the business day before. Our Practice closes at 5:00pm. It is your responsibility to call/text. If you do not call/text to confirm we may give your appointment away to another patient. <u>This will be considered a missed appointment.</u>

  Initials

- Timely Cancellations: If you need to cancel or reschedule your appointment you must give us 48 hours' notice. <u>Cancellations made with less then 48 hours' notice will be considered a missed appointment.</u> **<u>Saturday Appointments cannot be cancelled without being considered as failed.</u>**

  Initials

- On time arrivals: If you are more then 15 minutes late to your appointment, we may give your appointment away to another patient. <u>This will be considered a missed appointment.</u>

  Initials

- Compliance: Patients are allowed ONE missed appointment in a 12-month period. After the second missed appointment, you will not be scheduled appointments, but are welcome to use our clinic as a "walk-in" patient.

  Initials

Many Patients use Dr. Cale Beasley services. Your help in keeping your appointment enables us to provide better and timelier care for all our patients.

Patient or Parent/Guardian Signature **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement
If the patient is under 18 years of age, a parent or legal guardian must sign.

I, _____ have received a copy of this office Notice of Privacy Practices
{Please Print Patients Name}

_____
{Signature of Patient or Parent/Legal Guardian}

_____
{Date}

For patients who need pre-medication only:
I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whoever answers the telephone. I also authorize this office to remind me of my pre-medication on any post card reminders that the office will mail to me.

_____
{Signature of Patient or Parent/Legal Guardian}

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
- ☐ Patient reviewed Privacy Practices but elected not to take a copy home
- ☐ Other (Please Specify)

Employee Signature:_____ Date: _____

_____

_____

Office Policy

Payment will be expected at the time of service for all non-contracted fees and co-pays.

Insurance Contracts: If we have a "Participating Contract" with your insurance carrier, we will accept assignment on all covered services and bill your carrier for you. You are responsible for the Co-pay, coinsurance, and deductible and for all non-covered services.

If your insurance is found to be in force on the date dental services are provided, you will be responsible for the full balance base on usual and customary fees. A finance charge of 18% APR (1.5% a month) will be added to the total balance on all accounts over 60 days past due.

Third Party financing is available for patients requiring extensive treatment.

If at anytime you have questions regarding any treatment, fees, or services, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding, to rectify any injustice, or to preserve a friendship.

Missed appointments: Our policy is to charge for missed appointments unless cancellation received at least 48 hours in advance. **The charge is $50 per hour of scheduled time.**

Children in the office: Please make arrangements for your non-scheduled children prior to your visit. Children should not be left unattended in the reception area. All Children 17 years of age and under scheduled for treatment must have a parent or legal guardian present in the office during their appointment.

Cellular phones/pagers: We request all cellular phones and pagers be turned off or to silent mode during your appointment.

We reserve the right to Dismiss any patient from our practice for inappropriate behavior in our office or on the phone.

I Acknowledge that I am responsible to pay all charges for treatment administered by Littleton Dental Studio as outlined above and that if my account is placed with a collection agency for non-payment that I will be responsible for all collection costs, including court costs and associated attorney fees.

I have read the policies and agree with the terms outlined above.

Responsible Party Signature:_____

Printed Name: _____

Date: _____