WEDINGTON
FAMILY DENTAL

NEW PATIENT INFORMATION

The Following Information Is Confidential And For Our Records Only.

Date______/______/______

PATIENT INFORMATION

Name____
First Middle Last

Age________Gender ☐ Male ☐ Female Date of Birth ______/______/______ Marital Status __________

Email______________________________ Social Security # ____________________

Address____
Street City ST Zip Code

Phone________________________ Business Phone ________________________

Employer ______________________________ Occupation ____________________

SPOUSE INFORMATION

(Please fill out information below. If not applicable, skip).

Spouse's Name______________________________ Phone________________
First Last

Employer______________________________ Occupation ____________________

MINOR INFORMATION

(Please fill out information below if patient is under 18. If not applicable, skip).

Parent's Name(s)______________________________ Phone________________
First Last

PREVIOUS DENTAL INFORMATION

Previous Dentist ______________________________ Doctor's name______________________________________

Do You Have A Fear of Visiting The Dentist? ( ) Yes ( ) No If Yes, How Would You Rate Your Anxiety? _____________________________
(On a Scale of 1 - 10. 10 Being The Most.)

When Was Your Last Dental Visit? ( )0-6mths ago ( )6-12mnths Ago ( )1-3 years ( )3+yrs

What Did You Have Done During Your Last Dental Visit? ____

PRIMARY INSURANCE

Insurance Company__________________________________

ID #____

Name of Insured_____________________________________

Relationship to Patient ________________________________
(If name on card is different)

SSN _______________________ DOB _________________

Employer____

SECONDARY INSURANCE

Insurance Company __________________________________

ID # ____

Name of Insured _____________________________________

Relationship to Patient ________________________________
(If name on card is different)

SSN _______________________ DOB _________________

Employer ____

EMERGENCY CONTACT

Name____ Relationship ______________________
First Last

Phone____ Business Phone __________________________________

How Will You Be Paying? ☐ Cash ☐ Check ☐ Card ☐ Care Credit

INSURANCE RELEASE

I hereby authorize Wedington Family Dental to furnish to the above named insurance company(s) all information which said insurance company may request. I hereby authorize payment to be made directly to Wedington Family Dental, but not to exceed the charges incurred. I understand that I am responsible for payment not covered by my insurance.

Signature____ Date___________________________

REFERRAL INFORMATION

Please check one:

__ Friend/ Family __ Insurance __Internet search __Location __Other

Please tell us who we can thank for referring you!

Name: ____

PRIMARY PHYSICIAN INFORMATION

Primary Physician ______________________ Phone ______________________

Have You Been Under The Care of a Physician in the Past 2 Years? ☐ Yes ☐ No If Yes, Explain: ______________________

Are You Taking Any Medication? ☐ Yes ☐ No If Yes, Please List: ______________________

Have You Been Hospitalized or Had Any Surgeries in the Past 5 Years? ☐ Yes ☐ No If Yes, Explain: ______________________

Please Circle All That Apply To You:

Heart Attack Heart Surgery Heart Disease Chest Pains Congenital Heart Disease Heart Murmur Asthma

High/Low Blood Pressure Artificial Pins/Joints Rheumatic Fever Stroke Ulcers/Stomach Trouble Diabetes

Kidney Disease Tuberculosis Hepatitis A/B/C HIV Positive A.I.D.S Radiation/Chemotherapy Liver Disease

Neurological Disorder(s) Epilepsy/Seizures Fainting/Dizzy Spells Shortness of Breath Blood Thinners Anemia

Arthritis Migraines Psychiatric/Psychological Care MVP

Please List Any Condition(s) or Symptoms Not Mentioned Above: ______________________

Are You (or is there a chance you could be) Pregnant? ☐ Yes ☐ No If Yes, Due Date:____/____/____

Do You Smoke? ☐ Yes ☐ No If Yes, How Much? ______________________

Your Height______________ Your Weight ______________ lbs

Are There Any Changes You Would Like to Make or Are You Experiencing Any Discomfort Regarding Your Smile/Mouth?

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Wedington Family Dental to use and disclose protected health information about me to carry out treatment, payment and/or healthcare operations. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent.

With this consent, Wedington Family Dental may call my home or other alternative phone number and leave a message on voicemail or in person in reference to any items that assist the office in carrying out healthcare operations, such as: confirming appointments, insurance clarification or calls pertaining to my clinical care. They may also mail to my home any items regarding the prior information, such as patient statements and appointment reminders.

I understand that I can revoke my consent in writing except to the extent that the office has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Wedington Family Dental may decline any treatment to me thereafter.

Signature of Patient or Parent/Legal Guardian ____

Date________/________/________

INSURANCE

Due to the number of insurance carriers and their changing policies, we are unable to determine your exact insurance coverage. We can only provide you with general plan information at the time of your visit. For your protection, please don't assume that you have coverage without checking with your insurance carrier prior to treatment.

We require your co-payment and deductible (if applicable) on the day of your treatment prior to treatment. Your copayments are only an estimate. If there is a balance after insurance pays, a statement will be sent to you. Please allow 2-6 weeks for insurance payment on your claims. You are ultimately responsible for your bill regardless of insurance.

Please do not be hesitant to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. As a service for our patients, we will submit insurance claims at no charge. We will do all we can to assist you in maximizing your allowable benefits.

If we take assignment on your insurance, we feel that 45 days is a reasonable length of time for us to wait for payment from your insurance company. Should payment not be received within that time, payment of services rendered will be the responsibility of the patient.

NO INSURANCE

Patients without insurance will be required to pay in full on the day of treatment. We accept all major credit cards (MasterCard, Visa, Discover) and we also accept Care Credit.

OVERDUE ACCOUNTS

Accounts that are over 60 days past due could be placed with an outside collection agency for recovery. In the event that your account is turned over to an outside collection agency, a 30% collection fee will be added to your balance. Should it become necessary to collect an overdue account, the patient, or the patients' responsible party understands that Wedington Family Dental has the right to disclose all relevant account information necessary to collect payment(s) for services rendered.

There is a returned check fee of $25 for any returned checks.

NO-SHOW/CANCELLATION POLICY

We value your time with us, and expect the same in return. If you cannot keep your appointment, please give us a 24 Hour notice so that we can give this time to someone else. We charge a $25.00 fee for no show or cancellation of an appointment if we don't receive a 24 hour notice.

I have read and understand the above and agree to the terms and conditions.

Signature of Patient or Parent/Legal Guardian ______________________________

Date_______/______/_______

NOTICE OF PRIVACY PRACTICES

Notice Describes How Health Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review Carefully.

We are required by law to maintain the privacy of protected health information (PHI), to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in that Notice while it is in effect. The Notice took effect 10/01/2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy accounts, we will change this Notice and post the new Notice clearly and prominently at our practice location and we will provide copies of the new Notice upon request.

You may request a copy of the Notice at any time. For more information about our privacy practice or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
We may use and disclose your PHI for different purposes, including treatment, payment and health care operations. For each of these categories we have provided a description and an example. Some information such as HIV-related information, generic information alcohol and/or substance abuse records and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use and disclose your PHI for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment: We may use and disclose your PHI to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management and determinations of eligibility and coverage to obtain payment from you, an insurance company or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs and licensing activities.

Individuals Involved in Your Care or Payment For Your Care: We may use and disclose your PHI to your family and/or friends or any other individual identified by you when they are involved in your care or in payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make healthcare decisions for you, we will treat that patient representative the same way we would treat you in regard to your health information.

Disaster Relief: We may use or disclose your PHI to assist in disaster relief efforts.

Required By Law: We may use or disclose your PHI when we are required to do so by law.

Public Health Activities: We may disclose your PHI for public health activities, including disclosures to:

- Prevent or control disease, injury or disability
- Report child abuse or neglect
- Report reactions to medications or problems with products/devices
- Notify a personal of a recall, repair or replacement of products/devices
- Notify a person who may have been exposed to a disease or condition
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence

National Security: We may disclose to military authorities the PHI of Armed Force personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official(s) having lawful custody over the protected health information of an inmate or patient.

Security of HHS: We will disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation: We may disclose your PHI to the extent authorized by, and to the extent necessary, to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law or in response to a subpoena or court order.

Health and Oversight Laws: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs and compliance with civil rights laws.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose your PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communication(s).

Other Uses and Disclosures of PHI: Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing and for the sales of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access: You have the right to look at or receive copies of your PHI, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplied and labor of copying and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting disclosures of your health information in accordance applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction: You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured PHI as required by law.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our website or by email.

Questions and Complaints: If you want more information and our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations you may complain to us using the contact information listed at the end of the Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Dr. Rebecca Beauchamp

Telephone: 479.527.0707 **Fax:** 479.527.0201

Address: 1188 N. Salem Rd. Ste. 10, Fayetteville, AR 72704

Email: info@wedingtondental.com

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Patient Name: _______________________________________ Date: _______________

- I have been offered and/or received a copy of the currently effective Notice of Privacy Practices for Dr. Rebecca Beauchamp.
- I may refuse to sign
- Expiration: 3 years from initial/last signature; insurance change; patient reaches age of 18.
- I understand that I may request a copy of the privacy policies at any time.
- I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION

Name: __________________________ Relationship: ______________ Phone: ______________

Name: __________________________ Relationship: ______________ Phone: ______________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION AND INFORMATION ABOUT MY DENTAL HEALTH** VIA:

☐ Message on: ☐ Home Phone ☐ Cell Phone ☐ Work Phone
☐ Text
☐ Email
☐ U.S. Mail / Postcard
☐ Any of the above

___________________________________ ___________________________________
Please ***Print*** your name Please ***Sign*** your name

☐ Patient ☐ Parent ☐ Guardian ☐ Other____________________________