



The Following Information Is Confidential And For Our Records Only.

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? () 0-6 months ago () 6- 12 months ago () 1-3 years () 3+ years

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

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Company _____ Insurance Company _____

ID # _____ ID # _____

Name of Insured _____ Name of Insured _____

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

SSN _____ DOB _____ SSN _____ DOB _____

Employer _____ 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 _____

Pharmacy _____

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: _____

Do you have any allergies? Yes No If yes, please list: _____

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 MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Effective Date: February 5, 2026

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 on the date set forth at the top of this page and will remain in effect unless 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. A copy of the current Notice in effect will be available in our facility and on our website. 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.

Health Care 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 person 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.

Special protections for SUD records: If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment, or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purpose as described in the Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent of the order of a court after it provides you notice of the court order.

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.

Additional Restrictions on Use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

- 1) HIV/AIDS;
- 2) Mental Health;
- 3) Genetic Tests (in accordance with GINA 2009);
- 4) Alcohol and drug abuse;
- 5) Sexually transmitted diseases and reproductive health information; and
- 6) child or adult abuse or neglect, including sexual assault

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.

Date _____

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 with 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: Wedingtoncortdental@gmail.com

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Date _____ / _____ / _____



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: 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 _____

Date _____ / _____ / _____