Bethea
FAMILY DENTISTRY
Dental excellence made personal

4760 HARDSCRABBLE RD., STE. 102, COLUMBIA, SOUTH CAROLINA 29229
P: 803-462-4554 F: 803-832-1725 | WWW.BETHEAFAMILYDENTISTRY.COM

Welcome!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your optimal oral health and a smile you are proud to show off. **Please fill out this form as completely as possible.** We want to make sure that we are well informed about your medical history, current medications, and any other factors that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Today's Date:_____ How did you hear about us?_____

Name (First, Middle, Last):_____

I prefer to be addressed as:_____ Circle One: Male Female

Birthdate:_____ Age:_____ SS#:_____

Address:_____

City:_____ State:_____ Zip:_____

Email Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Employer:_____ Occupation:_____

Employer's Address:_____

City:_____ State:_____ Zip:_____

Circle One: Single Married Widowed Divorced Separated Partnered

Spouse's Name:_____

Spouse's Birthdate:_____ SS#:_____

Spouse's Employer:_____ Occupation:_____

When and where are the best times to reach you?_____

Other Family Members Seen by Us:_____

EMERGENCY CONTACT (Specify someone who does not live in your household)

Name:_____ Relationship:_____

Phone:_____

DENTAL INSURANCE

Person Responsible for Account (If other than yourself):_____

Do you have dental insurance coverage? **Yes** **No**

Dental Insurance Co. Name:_____

Dental Insurance Co. Address:_____

City:_____ State:_____ Zip:_____

Dental Insurance Co. Phone:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____ Relationship:_____

Insured's Birthdate:_____ SS#:_____

Insured's Home Phone:_____ Alt. Phone:_____

Insured's Employer:_____ Occupation:_____

ACKNOWLEDGMENTS & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Signature:_____

Date:_____

I understand that I will be required to pay my estimated portion of the doctor's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.

Signature:_____

Date:_____

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Medical History

Patient Name: _____ Birthdate: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
Name of physician: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medication containing oral or IV bisphosphonates? ☐ Yes ☐ No If yes, please explain: _____
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No List medications: _____
Pharmacy name and phone number: _____

Women: Are you pregnant/trying to get pregnant? Yes No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Iodine ☐ Barbiturates (sleeping pills) ☐ Sulfa Drugs ☐ Other

If yes, please explain: _____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS/HIV Positive	☐Yes ☐No	Cortisone Medicine	☐Yes ☐No	Hemophilia	☐Yes ☐No	Radiation Treatments	☐Yes ☐No
Alzheimer's Disease	☐Yes ☐No	Diabetes	☐Yes ☐No	Hepatitis A	☐Yes ☐No	Recent Weight Loss	☐Yes ☐No
Anaphylaxis	☐Yes ☐No	Drug Addiction	☐Yes ☐No	Hepatitis B or C	☐Yes ☐No	Renal Dialysis	☐Yes ☐No
Anemia	☐Yes ☐No	Easily Winded	☐Yes ☐No	Herpes	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Angina	☐Yes ☐No	Emphysema	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Rheumatism	☐Yes ☐No
Arthritis/Gout	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Hives or Rash	☐Yes ☐No	Shingles	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Excessive Thirst	☐Yes ☐No	Hypoglycemia	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Asthma	☐Yes ☐No	Fainting Spells/Dizziness	☐Yes ☐No	Irregular Heartbeat	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Blood Disease	☐Yes ☐No	Frequent Cough	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Spina Bifida	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No	Leukemia	☐Yes ☐No	Stomach/Intestinal Disease	☐Yes ☐No
Breathing Problem	☐Yes ☐No	Frequent Headaches	☐Yes ☐No	Liver Disease	☐Yes ☐No	Stroke	☐Yes ☐No
Bruise Easily	☐Yes ☐No	Genital Herpes	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Swelling of Limbs	☐Yes ☐No
Cancer	☐Yes ☐No	Glaucoma	☐Yes ☐No	Lung Disease	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Hay Fever	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Chest Pains	☐Yes ☐No	Heart Attack/Failure	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cold Sores/Fever Blisters	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No	Tumors or Growths	☐Yes ☐No
Congenital Heart Disorder	☐Yes ☐No	Heart Pacemaker	☐Yes ☐No	Parathyroid Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Convulsions	☐Yes ☐No	Heart Trouble/Disease	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Venereal Disease	☐Yes ☐No
						Yellow Jaundice	☐Yes ☐No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____

Date: _____

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Authorization & Release

Thank you for choosing Bethea Family Dentistry for your dental care. We hope to work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions. Benefits of dental treatment include: relief of pain, the ability to chew properly and enjoy eating, and the confidence and social interaction that a pleasing smile can bring. Common risks associated with virtually any dental procedure include:

- **Allergic reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
- **Long-term numbness (paresthesia).** Local anesthesia, or its administration, while almost always adequate to permit comfortable care, can result in temporary, or in rare instances, permanent numbness.
- **Muscle or joint tenderness:** Holding one's mouth open for prolonged periods of time, such as during dental treatment, can result in muscle or jaw joint tenderness. In a predisposed patient, it can precipitate a TMJ disorder.
- **Sensitivity in teeth or gums, infection, or bleeding.**
- **Swallowing or inhaling small objects.**

We follow procedural guidelines that most often lead to clinical success, but as in any other pursuit in health care, not everything always turns out the way it is planned. We will do our best to ensure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you for yourself and for your dependent(s).

Your signature below indicates that you have read and understand the general risks associated with dental treatment.

_____ _____

Signature of patient or parent/guardian, if minor **Date**

AUTHORIZATION & RELEASE & PAYMENT OPTIONS

- I authorize Bethea Family Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to the third party mayors and/or other health practitioners.

- I authorize and request my insurance company to pay directly to Bethea Family Dentistry insurance benefits otherwise payable to me.

- I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent(s).

I understand that I may be charged 1.5% finance charge per month (18% annually) if my balance goes beyond 60 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____

Patient's Signature **Date**

_____ _____

Doctor's Signature **Date**
(I have read, agree to, and understand the statements listed above.)

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act or 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payors.

- Conduct normal healthcare operations such as quality assessments and physicians certification.

I have received, read, and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosers of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient name: _____

Relationship to patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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Financial Arrangements

ALL PATIENTS PLEASE READ THE FOLLOWING...

Payment for services is expected at the time service is provided.

CANCELLATION POLICY

Please give us 24 hours' notice if you are unable to make your scheduled appointment.

IF YOU HAVE DENTAL INSURANCE

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will **estimate** your deductible and the portion not covered by your Insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have any questions about "UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

Print Name

Signature & Date

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Dental History

Why have you come to our office today? _____ Are you in pain? Yes No If yes, for how long? _____

Previous Dentist: _____ Phone: _____ Last Visit Date: _____

What was done? _____ Date of Last Cleaning: _____ Date of Last Dental X-rays: _____

Have you ever been told that you require antibiotics before dental treatment? Yes No

Do you have, or have you ever had, any of the following conditions, ailments, or treatments? Circle "Yes" or "No."

Bad Breath	Yes	No	Food Collection Between Teeth	Yes	No	Orthodontic Treatment	Yes	No
Bleeding Gums	Yes	No	Foreign Objects in Mouth	Yes	No	Pain Around Ear	Yes	No
Blisters on Lips or in Mouth	Yes	No	Grinding Teeth	Yes	No	Pain When Brushing	Yes	No
Broken Fillings	Yes	No	Gums Swollen or Tender	Yes	No	Periodontal Treatment	Yes	No
Burning Sensation on Tongue	Yes	No	Jaw Pain	Yes	No	Sensitivity to Cold	Yes	No
Chew on Only One Side	Yes	No	Jaw Fatigue	Yes	No	Sensitivity to Heat	Yes	No
Clenching of Teeth	Yes	No	Lip or Cheek Biting	Yes	No	Sensitivity to Sweets	Yes	No
Clicking or Popping of Jaw	Yes	No	Loose Teeth	Yes	No	Sensitivity When Chewing	Yes	No
Dry Mouth	Yes	No	Mouth Breathing	Yes	No	Sores or Growths in Mouth	Yes	No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No Do you ever experience pain in your jaw joint (TMJ/TMD)? Yes No

How would you classify your current dental health? Excellent Good Fair Poor Very Poor

On a scale of 1-10, how would you rate your smile (10 being the best)? _____

Would you like whiter teeth? Yes No Would you like fresher breath? Yes No What else about your smile would you like to change? _____

Do you feel anxiety about dental treatment? Yes No On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? _____

On average, how many times a day do you brush? _____ How many times a week do you floss? _____

What type of bristles does your toothbrush have? Soft Medium Hard

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Medical Update

Patient Name: _____

Date: _____

INFORMATION UPDATE

Are there any changes in your medical condition and/or any new medications? ☐ Yes ☐ No
Do you have any of the following?

1. Latex Allergy
2. Heart Murmur
3. Take Blood Thinners
4. Biphosphanates (Osteoporosis)
5. Mitral Valve Prolapse (MVP) Artificial bones/joints
6. Problems with Heart, Liver, Kidney
7. Allergies _____

If yes, please explain: _____

_____

Are there any changes in your address or phone number? ☐ Yes ☐ No

Are there any changes in your insurance coverage? ☐ Yes ☐ No

To process INSURANCE CLAIMS we need your signature on file. Please read and sign the following statement:

I agree to be responsible for all charges for dental services and materials not paid by the dental benefit plan. To the extent permitted under applicable law, I authorize release of information relating to this claim. I authorize payment of the dental benefits, otherwise payable to me, paid directly to Bethea Family Dentistry. My signature will be kept on file by their office.

_____
Signature

_____
Witness

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General Dentistry Informed Consent

Dentist: _____ Patient: _____

1. WORK TO BE DONE: I understand that I am having the following work done: Fillings ( ), Bridges ( ), Crowns ( ), X-rays ( ), Extractions ( ), Impacted Teeth Removed ( ), Root canals ( ), Dentures ( ), Other _____. (Initials _____)

2. DRUGS AND MEDICATION: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. (Initials _____)

3. CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. (Initials _____)

4. REMOVAL OF TEETH: Alternative to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the dentist to remove the following teeth: _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility. (Initials _____)

5. CROWNS, BRIDGES, AND CAPS: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 21 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that there will be additional charges for remakes due to my delaying permanent cementation. (Initials _____)

6. ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend though the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. (Initials _____)

7. PERIODONTAL LOSS (TISSUE AND BONE): I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements, and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition. (Initials _____)

8. FILLINGS: I understand that care must be exercising in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (Initials _____)

9. DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand the failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of 30 days, there will be additional charges. (Initials _____)

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for the payment of the dental fees. I agree to pay any attorney's fees, or court costs, that may be incurred to satisfy this obligation.

Signature of Patient: _____ Date: _____

Signature of Dentist: _____ Date: _____