Bethea
FAMILY DENTISTRY
Dental excellence made personal
GARY BETHEA, DDS

Patient Information

Date _____

Name_____ **SS#** _____-_____-_____
(last) (first) (middle initial) (full social required for anyone over 18)

Address_____
(Street) (APT #) (City) (State) (Zip Code)

DOB _____-_____-_____ **Gender (M) or (F)** **Relationship Status single married partner**

Cell Phone # _____-_____-_____ **E-Mail** _____

Employer or School _____ **Phone #** _____-_____-_____

Emergency Contact _____ **Phone #** _____-_____-_____

How did you hear about us? _____

*****PLEASE PROVIDE STATE ISSUED ID & INSURANCE CARD*****

YOU MUST COMPLETE ALL THE INFORMATION BELOW TO ENSURE PROPER PROCESSING OF YOUR CLAIM

Primary Subscriber is SELF / SPOUSE / PARENT **Secondary Subscriber is SELF / SPOUSE / PARENT**

Subscriber Name _____ **Subscriber Name** _____

Subscriber DOB_____-_____-_____ **Subscriber DOB**_____-_____-_____

Subscriber SS# _____-_____-_____ **Subscriber SS#**_____-_____-_____
**(PARENT'S SS# REQUIRED FOR ALL PATIENTS UNDER 18)

Subscriber Employer_____ **Subscriber Employer**_____

Ins Company_____ **Ins Company**_____

Ins Phone #_____ **Ins Phone #**_____

Ins ID #_____ **Ins ID #**_____

Ins Group #_____ **Ins Group #**_____

Medical Insurance Company _____ **phone #** _____

Subscriber ID/Member ID _____

4760 Hardscrabble Rd Suite 102, Columbia SC, 29229
Phone # 803-462-4554
email- office@betheafamilydentistry.com
Fax # 803-832-1725

Health History

Print Patient Name_____

Please check the box beside any medical condition for which you have been diagnosed*

	Alcohol / Drug Abuse		**Heart Valve Replacement**		**Pneumonia**
	Anemia		**Heart Pacemaker**		**Osteoporosis**
	Angina		**Hepatitis**		**Psychiatric Disorders**
	Artificial Bones or Joints		**Herpes**		**Respiratory / Lung Disease**
	Asthma		**High Blood Pressure**		**Shortness Breath**
	Blood / Bleeding Disorder		**High Cholesterol**		**Sinus Problems**
	Cancer / Tumor/		**HIV / AIDS**		**Stomach Ulcers**
	Cardiovascular Disease		**Hormone Problems**		**Stroke**

	Covid-19		**Hypoglycemia**		**Thyroid Problems**
	Diabetes		**Kidney Disease**		**TMJ**
	Heart Disease		**Liver Disease**		**Tuberculosis**
	Heart Murmur		**Low Blood Pressure**		**AUTISM or Developmental Delays**

ALLERGIES

	ASPRIN		**IODINE**		**NSAIDS**
	ACRYLIC		**LATEX**		**PENICILLIN**
	BARBITUATES		**LOCAL ANESTHETICS**		**SULFA DRUGS**
	CODEINE		**METALS**		**OTHER ALLERGIES NOT LISTED**

OTHER ALLEGERIES NOT LISTED ABOVE_____

ADDITIONAL MEDICAL CONDITIONS:_____

Have you ever taken medication for Osteoporosis? YES NO Date? _____

Please list all Medications that you are taking _____

_____.

Women: **Taking oral contraceptives?** **YES** **NO**

Pregnant or Trying to? **YES** **NO**

Breastfeeding? **YES** **NO**

Patient Signature:_____

(PARENT / GUARDIAN SIGNATURE IF PATIENT IS UNDER 18)

FINANCIAL POLICY

Print Patient Name _____

Guarantor if Patient is under 18 _____

Guarantor's DOB_____-_____-_____ **Guarantor's SS#**_____-_____-_____

Required for patients under the age of 18

PLEASE READ CAREFULLY AND INTIAL BELOW

_____ **PAYMENT FOR SERVICE IS COLLECTED BEFORE TREATMENT IS PROVIDED ON DATE OF SERVICE**

_____ **ALL APPOINTMENTS MUST BE CONFIRMED VIA TEXT OR VOICE CALL TO OUR OFFICE 7 DAYS PRIOR TO YOUR APPOINTMENT IN ORDER TO HOLD YOUR APPOINTMENT TIME.** ***WE DO HAVE A CONFIDENTIAL VOICEMAIL TO LEAVE MESSAGES ON REGARDING YOUR APPOINTMENT***

DENTAL INSURANCE

AS A COURTESY TO YOU, OUR OFFICE WILL FILE A DENTAL CLAIM WITH YOUR INSURANCE COMPANY IN AN EFFORT TO MAXIMIZE YOUR BENEFITS. WE CAN ONLY ESTIMATE WHAT INSURANCE MAY PAY. THIS ESTIMATE MAY INCLUDE YOUR DEDUCTIBLE AND THE PORTION NOT COVERED BY YOUR INSURANCE. HOWEVER, THIS IS NOT A GUARANTEE OF PAYMENT; YOU WILL ULTIMATELY BE RESPONSIBLE FOR ALL FEES ASSOICIATED WITH TREATMENT PROVIDED BY OUR OFFICE. WE REQUIRE 100% PAYMENT OF YOUR ESTIMATED PATIENT PORTION AT TIME OF SERVICE OR ON PREP/IMPRESSION DATE.
IF YOU HAVE QUESTIONS WITH THE AMOUNT YOUR INSURANCE COMPANY HAS PAID OR WILL PAY PLEASE CALL YOUR INSURANCE CARRIER.
*****IF YOUR INSURANCE IS OUT OF NETWORK WITH BETHEA FAMILY DENTISTRY YOU WILL BE REQUIRED TO PAY FOR YOUR VISIT IN FULL AND WE WILL REIMBURSE YOU ONCE YOUR INSURANCE HAS PAID.***

PLEASE INTIAL BELOW THAT YOU UNDERSTAND

_____ I ACKNOWLEDGE AND UNDERSTAND THAT MY PATIENT PORTION IS ONLY AN ESTIMATE AND I AM RESPONSIBLE FOR THE COST OF ANY AND ALL PORTIONS LEFT UNPAID BY THE INSURANCE COMPANY.

_____ I AM FINACIALLY RESPONSIBLE FOR ANY AND ALL TREATMENT REGARDLESS OF INSURANCE STATUS.

_____ I UNDERSTAND THAT ANY CLAIM DENIED BY MY INSURANCE WILL AUTOMATICALLY BECOME THE RESPONSIBILITY OF THE PATIENT OR PARENT, IF THE PATIENT IS UNDER 18.

_____ BETHEA FAMILY DENTISRTY ACCEPTS THE FOLLOWING TYPES OF PAYMENT CASH, CHECK, CREDIT CARD, PAYMENT FOR INURANCE COMPANIES, AND CARE CREDIT. WE DO NOT OFFER ANY TYPE OF FINANCING.

PATIENT SIGNATURE _____

PARENT'S SIGNATURE IF PATIENT IS UNDER 18

**Initial the boxes below
& sign the bottom

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GENERAL DENTISTRY INFORMED CONSENT

Dentist: Dr. Bethea Patient: X

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: X _____ Date: _____

Signature of Dentist: _____ Date: _____

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

☑ Cell Phone Confirmation
☑ Text Message to my Cell Phone
☑ Home Phone Confirmation
☑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☑ Cell Phone Confirmation
☑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

As a healthcare provider, we may receive substance use disorder records, which are protected under title 42 of the Code of Federal Regulations Part 2. 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 or the order of a court after it provides you notice of the court order.

Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment 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.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

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OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe) _____

Signature of Privacy Officer _____

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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

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	**No**
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date

_____

Witness