BEYOND DENTISTRY clearwater

Welcome to Our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___ - ___ - _____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name, Relationship and Phone number below:

_____

_____

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID#:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID#:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ ADHD
- ☐ Arthritis
- ☐ Bisphosphonates-IV
- ☐ CHD
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Lymphoma
- ☐ Mitral Valve Prolapse
- ☐ Vent/Tachycardia
- ☐ Respiratory Problems
- ☐ Stroke
- ☐ Trigeminal Neuralgia
- ☐ AIDS
- ☐ Drug Allergies
- ☐ Artificial Joints
- ☐ Bisphosphonates-oral
- ☐ COPD
- ☐ Emphysema
- ☐ Fainting
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Leukemia
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Seasonal Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disease
- ☐ Crohn's Disease
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Heart Murmur
- ☐ HIV
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Radiation
- ☐ Sleep Apnea
- ☐ Surgery Vent
- ☐ Acid Reflux
- ☐ Anxiety
- ☐ Cancer
- ☐ Depression
- ☐ Glaucoma
- ☐ Hemophilia
- ☐ Joint Replacement
- ☐ Lupus
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Stomach Problems
- ☐ Thyroid problem
- ☐ Vertigo
- ☐ Other

- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Currently Pregnant

If any condition or alerts selected above needs further clarification, please explain below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of physician and their specialty:

Most recent physical exam and purpose:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

List all medications, supplements, and/or vitamins taken within the last two years:

☐ * **By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long you have been a patient there:

_____

_____

Date of most recent dental exam: _____ **Date of most recent dental x-rays:** _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted
☐ Had any teeth removed

Please describe further if needed:

_____

_____

_____

_____

BEYOND DENTISTRY clearwater

General Consent

I hereby authorize Dr. Alqasemi and/or Dr. Adham and whomever they may designate as an assistant, to perform upon me the procedures listed in my treatment plan. I request and authorize them to do what they deem advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling in their judgement, for procedures in addition to or different from those now contemplated

I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case and understand that there is a slight element of risk inherent in the administration of any drug. This risk includes but is not limited to adverse drug response (eg. allergic reactions), cardiac arrest, aspiration, thrombophlebitis (eg imitation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from the anesthetic injection. I also understand that temporary or permanent injury to nerves and/or blood vessels from the injection may occur. Nerve disturbances may include pain or numbness, and/or unusual sensations such as itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infections, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g. numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing and aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require further surgery for removal

I realize that despite the possible complications and risks, my contemplated surgery/treatment is necessary and desired to me. I am aware that the practice of dentistry and surgery and the desired outcome can vary based on biological factors. I acknowledge that no guarantees have been made to concerning the results of the operation or procedure I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow all instructions as explained and directed to me and permit prescribed diagnostic procedures.

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I understand that undergoing dental care and treatment may increase the risk of respiratory virus or other infections. I understand that healthcare personnel or others from the community may be carriers of a respiratory virus or other infections and may not show disease symptoms, even if infected. I understand that my dental procedure, or procedures performed on other patients before or during my dental visit, may result in the creation of an aerosol (droplets in the air). The presence of aerosol may increase the risk of infection with a communicable disease as a result of breathing in droplets that contain disease-causing germs. One example of this exposure is coronavirus and COVID-19 infection. I also understand that the office of Drs. Adham and Alqasemi complies with current infection prevention and control guidelines and that all appropriate steps are being taken to lower the risk of transmission and infection by disease-causing viruses or bacteria during my dental visit. This protocol includes work practice controls, procedures and protective equipment to help prevent infections that may be passed on through close contact, respiration (breathing), or exposure to infected blood or saliva.

☐ By checking this box I acknowledge that I have read this General Consent statement and agree to the contents.

Signature of Patient, parent, or guardian (responsible party):

Signature _____ Date _____

Name and relationship to patient:

_____

2701 Park Drive Suite 4
Clearwater, FL. 33763

(727) 304-3156
Frontdesk@BeyondDentistryfl.com

BEYOND DENTISTRY clearwater

Authorization for Treatment

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.
I authorize the dentist to release my information including the diagnosis and records of treatment of examination for myself and my insurance carrier to submit payment directly to the dentist practice to be applied directly to any outstanding balance on my account.
I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for the remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf of my dependents (if any).

☐ By checking this box I acknowledge that I have read this statement and agree to the contents.

Signature of Patient, parent, or guardian (responsible party):

Signature _____ Date _____

Name and relationship to patient:

_____

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Cancellation and No Show Policy

Your appointment is very important to us and the appointments we book are reserved specifically for you.

We understand that sometimes schedule adjustments are necessary and life can be a little unpredictable. Therefore, we respectfully request that you provide us with at least 24 hours' notice for any cancellation. Please understand that when you forget or cancel your appointment without giving us proper notice, we miss the opportunity to fill that appointment time. Because of this, patients on our waiting list may miss a chance to receive treatment that they have been waiting to schedule.

Any appointments cancelled with less than 24 hours' notice will be charged a $50 canceled appointment fee. We understand some unavoidable circumstances may cause you to cancel within the 24 hours' time frame and fee may be waived upon approval.

Patients who do not call to cancel their appointment and do not show up will be considered a 'no-show'. Patients who 'no-show' two (2) or more times in a 12-month period will be required to make a non-refundable pre-payment for the next appointment to be made. We hold the right to deny future appointments if 'no-shows' continue.

☐ By checking this box I acknowledge that I have read this statement and agree to the contents.

Signature of Patient, parent, or guardian (responsible party):

Signature _____ Date _____

Name and relationship to patient:

_____

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Financial Policy

Payment for services, including deductibles and copayments, are due at the time of the service unless other arrangements have been made prior to treatment. If billed by the office due to prior arrangements, payment is due within thirty (30) days of billing. Payments may be made using cash, or credit cards. Any arrangements for third-party financing must be made before starting treatment.

Although Beyond Dentistry accepts most dental benefit plans, you are ultimately responsible for all charges. We are happy to submit the claims necessary to see that you receive your benefits. The insurance contract is an agreement between you and the insurance company therefore we cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed. In order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that dental insurance is intended to cover some but not all dental care costs, and not all services are covered by your plan. You are responsible for payment of all services regardless of the payable benefit. Checks that are returned to our office from your financial institution are subject to a $35 returned check fee*. This fee covers the processing fees that are charged to our office.

We would be happy to discuss our charges and how they relate to your particular situation. Please indicate your understanding and acceptance of these financial policies by signing below.

☐ By checking this box I acknowledge that I have read this statement and agree to the contents.

Signature of Patient, parent, or guardian (responsible party):

Signature _____ Date _____

Name and relationship to patient:

_____

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Notice of Privacy Practices

I understand that I have certain nights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following:

Treatment (including direct and indirect treatment by other health providers involved in my treatment
Obtaining payment from third party payers (e.g. my insurance company
The day-to-day healthcare operation of your practice

I acknowledge that I have been offered a copy of the currently effective Notice of Privacy Practices for this healthcare facility which contains a more complex description of the uses and disclosures of my protected health information and my night under HIPAA understand that you reserve the right to change terms of the notice from time to time and that I may contact you at any time to obtain the current copy of the notice. 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 doctors/facilities in the future.

In addition, I authorize the following individuals (example: spouse, parent/grandparent, sibling) to have access to and be informed of this patient's dental/medical information and dental/medical care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you do not list anyone, we WILL NOT share any information regarding your account.

☐ By checking this box I acknowledge that I have read this statement and agree to the contents.

Signature of Patient, parent, or guardian (responsible party):

Signature _____ Date _____

Name and relationship to patient:

_____

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Consent to Electronic Communications

Our Practice our contractors on our behalf, may utilize the contact information you have provided to us to send you information including appointment reminders, appointment scheduling and treatment reminders, and promotional messages about other services and products that we may offer.

By providing your contact information, including your email address and cellar phone number, you give express written consent to receive communications through emails, and text messages to your cellular phone. You understand that the email communications and text messages you are agreeing to receive may include treatment reminders as well as promotional messages. Unencrypted email and text messages are not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. We will use the minimum necessary amount of protected health information in any communication.

Your consent means you agree to receive unsecure emails and text messages and understand the risks. Message and data rates from your cellular carrier may apply for text messages. You understand I can add or withdraw my consent at any time. You are responsible to notify us immediately if your phone number or email address changes.

Text Messages:

☐ Yes- I consent to communication via text messages.
☐ No- I do not consent to communication via text messages.

Email Messages

☐ Yes- I consent to communication via email.
☐ No- I do not consent to communication via email.

Email Address: _____

Cell Phone Number: _____

☐ By checking this box I acknowledge that I have read this statement and accept the above mentioned risks.

Signature of Patient, parent, or guardian (responsible party):

Signature _____ Date _____

Name and relationship to patient: _____

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