W.K. BELTON, JR., D.M.D., PA

Changing Smiles

We would like to welcome you to our practice. This first visit is considered very important to both the patient and Dr. Belton. Because of this, we schedule at least one hour to spend with you.

The visit begins with:

- Dental and Medical History review
- The patients' dental desires and goals
- Digital radiographs (filmless, lower radiation), intra oral photos
- Complete oral examination
- TMJ examination
- Occlusal (bite) alignment examination
- Soft tissue examination
- Periodontal measurements
- Visual oral cancer screening, oral cancer testing can be done

At the conclusion of the first visit you should have a very good understanding of your current dental health. Any dental treatment that may be needed will be discussed with you, and a written treatment plan provided. The treatment plan can include an estimate of any insurance benefits you may have.

We believe this will be the most thorough First Visit/Oral Examination you will ever have. Our goal is always to insure you are comfortable and enjoy this experience. This is not a 5 minute exam, and is a foundation to a good dental health relationship that will allow you to achieve the best oral health possible, and maintain that for a life time.

For patients with emergency needs, we will treat one emergency concern. After this visit we ask that you return for a complete examination, full series of radiographs and treatment planning to avoid further emergencies. This will allow us to establish the necessary relationship to keep you in the best dental health long term.

In this packet we have included the necessary forms for our records, if you would be so kind as to complete the forms and bring them with you to your appointment, this will expedite the check in process. *If you do not have the opportunity to print and complete the forms prior to your scheduled appointment, please arrive 15 minutes before your dental appointment to complete the forms.*

If you have had radiographs taken under your dental insurance frequency limitations, please contact the previous provider for a digital transfer of records.

We look forward to meeting with you soon.

The Office of William K. Belton Jr., DMD

510 Vonderburg Dr., Ste 211, Brandon, FL., 33511 * (P) 813-689-5098 * (F) 813-681-4698 * www.DrBelton.com

TIME DATE

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

REFERRED BY:

EMERGENCY CONTACT/#

PREVIOUS DENTIST

YOUR OCCUPATION

CARE CREDIT

AM EXPRS

MASTER CARD

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time

William K. Belton Jr., DMD

Date

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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 Problems	○ 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	Tonsilitis	○ 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 If yes

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:

X

Date:_____

W.K. BELTON, JR., D.M.D., PA

Changing Smiles

Financial Agreement & Office Guidelines for William K. Belton Jr., D.M.D.

Our philosophy is to make our patients lives healthier and more comfortable by providing high quality, compassionate dental care.

In an effort to keep fees reasonable and to continue to provide quality care, we have established payment guidelines. Our administrative team will be happy to bill your primary dental insurance carrier. However, we do require payment of any uncovered services, deductibles, or co-payments to be taken care of at each appointment.

1. All dental treatment will be paid in full at the time the treatment is rendered, according to estimated insurance benefits.

2. Insurance claims are filed as a courtesy. *Insurance is a contract between the insured and the insurance company. Therefore our office is not responsible for any erroneous information given to you by the insurance company. It is the patient's responsibility to understand the details of the insurance policy. We will offer help understanding your policy however, our primary concern is your dental health.*

3. Treatment Plans can be provided and are based on an ESTIMATE of insurance benefits. Insurance benefits cannot be guaranteed at any time.

4. Co-payment for any service is to be paid at the time service is rendered. Any concerns regarding co-payments shall be addressed **PRIOR** to the appointment. Some procedures may require a deposit

5. Acceptable forms of payment are cash, check, or any major credit card. We also accept CareCredit, please discuss what plans are available with our treatment coordinators.

6. Late Canceled (less than 48 hours) or Broken appointments are charged $55.00 fee. Late arrivals may need to be rescheduled.

I understand that fees for services may change without prior notice. I understand that the fee schedules are provided by either my insurance company, my employer, and/or William K. Belton Jr. D.M.D. I understand that my insurance carrier reserves the right to downgrade or make payment on alternate benefits at any time which can result in my insurance carrier paying a reduced amount toward services rendered and resulting in a balance due on my account. I understand that I am responsible for any and agree to pay any balance remaining on the account. Ultimately the final balance can only be determined when a claim for service has been paid by my insurance carrier and the Explanation of Benefits has been received. I understand that William K. Belton Jr .D.M.D. is not responsible for your insurance carriers claim processing and payment.

I have read, understand, and agree to the financial agreement & office policy outlined above.

_____ _____

Signature of Patient / Legal Guardian *Date*

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W.K. BELTON, JR., D.M.D., PA

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of_____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that late charges may be added to my account.

5. I have been given a copy of the HIPAA Notice of Privacy Policies. I have read and understand this form. I am signing voluntarily. I authorize the disclosure of my health information as described in this form.

Patient's Signature_____

Date:_____.

Parent /Responsible Party's Signature:_____

Relationship to Patient:_____

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Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased risk: patients ages 18-39
High risk: patients age 40 and older; tobacco users (any age, any type within 10 years) Highest risk: patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated ViziLite® Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is $40.

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____

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William K. Belton Jr., D.M.D., PA Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At the office of William K. Belton Jr., D.M.D., we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Tina Johnson, at (813) 689-5098 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of the William K. Belton Jr., D.M.D., Notice of Privacy Practices. Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____

W.K. BELTON, JR., D.M.D., PA

Changing Smiles

INFORMED CONSENT TO RELEASE RECORDS and USE and DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to and request of any and all dental records to William K. Belton Jr., DMD.

Patient's Name:_____ Patient's DOB:_____

Patient's Signature;_____
(Parent if minor)

Date:_____

Please Email Digital Images

FMX Within 3-5 yrs
Bitewings Within 12 mths

office@doctorbelton.com (Dexis or JPG format)

Please do not fax films as they are of no diagnostic quality.

Dentist/ or Dental Office:_____

Contact number:_____

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