# PATIENT INFORMATION

Today's Date _____

Name _____ Sex M / F Birthdate _____ SSN _____
Address _____ City _____ State / Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-Mail _____ _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Spouse or Parent Name _____ Birthdate _____ SSN _____
In case of emergency, who should be notified? _____ Phone _____
Whom may we thank for referring you? _____

## Employment Information

Patient employed by _____ Phone _____
Spouse or Parent employed by _____ Phone _____

**Student Information** School Name _____ Full or Part Time _____

## Insurance Information

**Primary Insurance**
Name of Insured _____ Relationship to patient _____
Birthdate _____ SSN _____ Ins. ID # _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Group # _____ Ins. Phone # _____
Ins. Co. Address _____ City _____ State / Zip _____

**Secondary Insurance**
Name of Insured _____ Relationship to patient _____
Birthdate _____ SSN _____ Ins. ID # _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Group # _____ Ins. Phone # _____
Ins. Co. Address _____ City _____ State / Zip _____

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize Dr. Robert Beebe, Jr. and/or Dr. Sharon L. Clark to release any information, including the diagnosis and the records of any treatment or examination rendered to me, or my dependent(s), during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay all insurance benefits directly to the dentist or dental group otherwise payable to me. I understand that my dental benefit plan 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 the parent who brings the child in for treatment is financially responsible.

_____ _____
**Signature of Patient, Parent or Guardian** **Date**

# PATIENT MEDICAL HISTORY

Physician:_____ Office Phone: _____ Date of Last Exam:_____

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operations or serious illness? | ☐ | ☐ |

_____

_____

_____

| | | |
|---|---|---|
| 3. Are you taking any medication(s), non-prescription medicine? | ☐ | ☐ |

If yes, what medication(s) are you taking?

_____

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 4. Do you use tobacco? | ☐ | ☐ | Do you use alcohol? | ☐ | ☐ |
| 5. Do you use other drugs? | | | | ☐ | ☐ |

6. Are you allergic to or have you had any reactions to the following?

| | | | | | |
|---|---|---|---|---|---|
| Local Anesthetics (e.g. Novocaine) | ☐ | ☐ | Aspirin | ☐ | ☐ |
| Penicillin or Other Antibiotics | ☐ | ☐ | Any Metals (e.g. Nickel, Mercury, etc.) | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ | Latex Rubber | ☐ | ☐ |
| Barbiturates | ☐ | ☐ | Other | ☐ | ☐ |
| Sedatives | ☐ | ☐ | _____ | | |
| Iodine | ☐ | ☐ | _____ | | |

7. Date of Last Dental Visit _____
   Date of Last Cleaning _____
   Dentist's Name _____ Telephone Number _____
   Last Date if known:
   Bitewing X-rays _____
   Full Mouth X-rays _____
   Panorex X-rays _____

8. **Women Only:**

| | | |
|---|---|---|
| a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking birth control pills? (Antibiotics may affect birth control pills) | ☐ | ☐ |

9. Do you have or have you had any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease | ☐ | ☐ | Stomach Trouble/Ulcers | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Easily Winded | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | Mitro Valve Prolapse | ☐ | ☐ | Stroke | ☐ | ☐ |
| Fainting/Seizures | ☐ | ☐ | Angina | ☐ | ☐ | Hay Fever/Allergies | ☐ | ☐ |
| Asthma | ☐ | ☐ | Frequently Tired | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Anemia | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Epilepsy/Convulsions | ☐ | ☐ | Emphysema | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Cancer | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Arthritis | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | Joint Replacement | | | Heart Trouble | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ | or Implant | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | Hepatitis/Jaundice | ☐ | ☐ | Other | ☐ | ☐ |

Updated Signature _____ Date _____
Updated Signature _____ Date _____
Updated Signature _____ Date _____
Updated Signature _____ Date _____

# FINANCIAL POLICY

Robert G. Beebe Jr. DMD, PA
Sharon L. Clark, DMD
Nancy B Evans, DMD

Thank you for choosing our office for your dental care. You and your family's dental health and well-being are our primary concern. We hope that the information provided answers many of the questions you might have about our services, policies, and procedures.

**The First Appointment**
On the first appointment, a thorough examination in all areas of your mouth will be done in order to accurately assess your dental needs. This will include a detailed examination of the teeth, any necessary x-rays. A Registered Dental Hygienist will clean your teeth and you will receive a personalized treatment plan if any additional procedures are needed.

**Treatment Plan**
Your personalized treatment plan will include ADA procedure codes, teeth numbers, our fees and the estimated portion due for each procedure. The estimated amount is based on what **most** insurance companies pay for each ADA procedure code. The amount **your** insurance company pays may vary depending on the plan your employer purchased. To obtain an exact estimate, you must call your insurance company. The estimated amount must be paid on the day of treatment. After your insurance company pays, additional amounts may be due if your insurance pays less than estimated. You will be billed for any additional amounts due. $5.00 repeat billing fee will be charged to any account not paid in 30 days.

We provide you with ADA procedure codes so that you can contact your insurance company if you prefer to get the exact amount of coverage per procedure.

**Insurance**
As a courtesy, we will be happy to file claims for up to two carriers at no charge. It is important to remember that your insurance contract is between you and your employer. Coverage varies from carrier to carrier, as does their calculation of "usual and customary fees". You will be legally responsible for any amounts not covered by your insurance. Our office will not be responsible for settling any dispute between you and your insurance carrier over a claim, but we will assist you in any way we can.

In order for us to file your claim, provide our office with an insurance card, plan number and mailing address.

**Payment**
In an effort to control our costs while maintaining a superior level of professional care, charges are payable at the time services are rendered. For your convenience we have established the following payment options:

1. Payment in full, or payment of the estimated portion that your insurance will not cover, is due on the day services are rendered.
2. We can assist you in opening a CARECREDIT revolving credit account
3. Monthly payment arrangements can be made for a balance over $300.00 **ONLY** with an auto debit authorization to your debit or credit card. Balance must be paid with a maximum of 3 monthly payments.

Our team of doctors and staff are committed to providing you with the best available, state-of-the art treatment in a relaxed caring environment. We take great pride in our training, dedication and continuing education. Your suggestions and comments are always welcome. Do not hesitate to discuss any questions or concerns with our office.

_____ _____

**Patient Signature** **Date**

# *Robert G. Beebe, Jr., DMD, PA*

## Acknowledgement of Receipt Of Notice of Privacy Practices

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature Date

## Authorization to Release Health Information to Family Members

_____ _____
Name of Patient Date of Birth

I hereby authorize all providers and personnel of Robert G. Beebe, Jr., DMD, PA to discuss my protected health information with:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand that certain information cannot be released without specific authorization as required by state and federal law. I understand that I have the right to revoke this authorization, in writing at any time.

_____ _____
Signature of Patient/Personal Representative Date

F:/softdent/letters/HIPPA form.doc