Date ______ SS/HIC/Patient ID # ______ Birthdate ______

Name of Minor/Child ______ Sex ☐ M ☐ F Age ______
Last Name First Name Middle Initial

Nickname ______ Hobbies ______ Cell Phone (____) ______

Home Address ______
Street City State Zip

Mailing Address ______
Street City State Zip

School Name ______ School Phone (____) ______

Person financially responsible ______ Home Phone (____) ______ Work Phone (____) ______

Whom may we thank for referring you? ______

Father's / Guardian's Name ______

Address (if different from patient's) ______

______

Home Phone (____) ______ (if different from above) Work Phone (____) ______ (if different from above)

E-mail ______

Employer ______

Soc. Sec. # ______ Birthdate ______

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ______ Phone (____) ______

Address ______

Group # ______ Policy # ______

Mother's / Guardian's Name ______

Address (if different from patient's) ______

______

Home Phone (____) ______ (if different from above) Work Phone (____) ______ (if different from above)

E-mail ______

Employer ______

Soc. Sec. # ______ Birthdate ______

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ______ Phone (____) ______

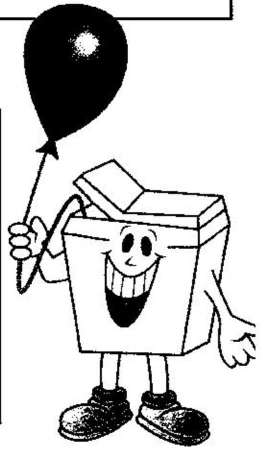
Address ______

Group # ______ Policy # ______

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # ______

Date of last visit to a dentist ______ For what service? ______

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	☐	☐



(Vers.D2SSS04)

Please Complete Both Sides

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Minor/Child's Physician ______ City/State ______ Phone (____) ______

Date of last physical examination ______ Results ______

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications ______

Allergies ______

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

In the event of an emergency, whom should we contact?

Name ______ Relationship ______ Phone (____) ______

Name ______ Relationship ______ Phone (____) ______

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of ______
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

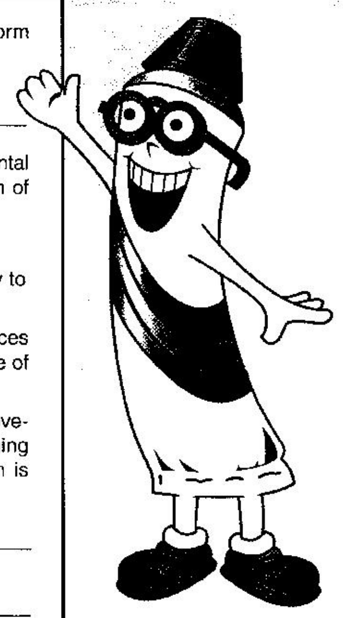
I certify that my dependent(s) is covered by insurance with ______ and assign directly to
Name of Insurance Company(ies)

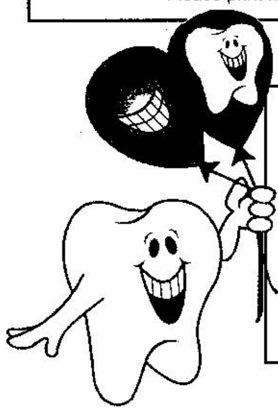
Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

______ Signature of Parent, Guardian or Personal Representative ______ Date

______ Please print name of Parent, Guardian or Personal Representative ______ Relationship to Patient





TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe ______

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list ______

Date ______ Parent/Guardian Signature ______

Date ______ Dentist Signature ______

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