PATIENT INFORMATION

Date_____ SS#_____
Patient
Name _____

Address _____

_____

Home Phone _____
Drivers License # and State

_____
Sex: □M □F Age_____ Birthdate_____
Occupation_____
Employer_____
Employer Phone #_____

RESPONSIBLE PARTY/ PARENT/ SPOUSE

Name_____
Birthdate_____ SS#_____
Occupation_____
Employer_____
Other family members seen by us:
_____

The following are additional forms of communication that are optional and do not have to be filled in if one chooses not to. One's e-mail will be for newsletters from this office only and to communicate about future appointments only and will not be given out to anyone.

Cell phone_____
e-mail_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

_____
(Name) (Relationship)

_____
(Home Phone) (Work Phone)

MEDICATIONS

List any medications (also herbal) you are taking and the correlating diagnosis: _____
_____
_____
_____
Pharmacy Name_____

ALLERGIES

□Aspirin	□Latex	□Sulfa
□Benzocaine	□Local Anesthetic	□Other _____
□Codeine	□Metals	_____
□Iodine	□Penicillin	_____

DENTAL HISTORY

Reason for today's visit _____
_____
Former Dentist_____
City, State_____
Date of last dental visit_____
Date of last dental X-rays_____

Place a mark on "yes" or "no" to indicate if you have or have had any of the following in the past:

Bad breath	□ Yes	□ No
Bleeding gums	□ Yes	□ No
Blisters on lips or mouth	□ Yes	□ No
Burning sensation on tongue	□ Yes	□ No
Chew on one side of mouth	□ Yes	□ No
Cigarette, pipe, or cigar smoking	□ Yes	□ No
Clicking or popping jaw	□ Yes	□ No
Dip or chew tobacco	□ Yes	□ No
Dry mouth	□ Yes	□ No
Fingernail biting	□ Yes	□ No
Food collection between the teeth	□ Yes	□ No
Grinding teeth	□ Yes	□ No
Gums swollen or tender	□ Yes	□ No
Jaw pain or tiredness	□ Yes	□ No
Lip or cheeck biting	□ Yes	□ No
Loose teeth or broken fillings	□ Yes	□ No
Mouth breathing	□ Yes	□ No
Mouth pain when brushing	□ Yes	□ No
Orthodontic treatment	□ Yes	□ No
Pain around ear	□ Yes	□ No
Periodontal treatment	□ Yes	□ No
Sensitivity to cold	□ Yes	□ No
Sensitivity to heat	□ Yes	□ No
Sensitivity to sweets	□ Yes	□ No
Sensitivity when biting	□ Yes	□ No
Sores or growths in mouth	□ Yes	□ No
Tongue Bar/Mouth Piercing	□ Yes	□ No

How often do you floss? _____
How many times do you brush? _____
Do you use mouth rinse? □ Yes □ No
Type/Brand _____
Have you ever had any problems or complications with previous dental treatment? □ Yes □ No
_____
If we could wave a magic wand and change anything about your smile, what would it be?
_____

If we could offer you a simple, inexpensive way to whiten your teeth, would you be interested?
_____

HEALTH HISTORY

Physician's Name_____

Date of last visit_____

Have you ever taken any of the group drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Mark "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	□ Yes	□ No
Anemia	□ Yes	□ No
Anxiety Attacks	□ Yes	□ No
Arthritis/Rheumatism	□ Yes	□ No
Artificial Heart Valves	□ Yes	□ No
Artificial Joints/Bones	□ Yes	□ No
Asthma	□ Yes	□ No
Back Problems	□ Yes	□ No
Bleeding abnormally, with extractions or surgery	□ Yes	□ No
Blood Disease/Transfusions	□ Yes	□ No
Cancer	□ Yes	□ No
Chemical Dependency	□ Yes	□ No
Chemotherapy	□ Yes	□ No
Circulatory Problems	□ Yes	□ No
Claustrophobia	□ Yes	□ No
Congenital Heart Lesions	□ Yes	□ No
Cortisone Treatments	□ Yes	□ No
Cough, persistent or bloody	□ Yes	□ No
Diabetes	□ Yes	□ No
Difficult Breathing	□ Yes	□ No
Do you wear contact lenses?	□ Yes	□ No
Drug/Alcohol Abuse	□ Yes	□ No
Emphysema	□ Yes	□ No
Epilepsy/Seizures	□ Yes	□ No
Fainting or Dizziness	□ Yes	□ No
Glaucoma	□ Yes	□ No
Headaches	□ Yes	□ No
Heart Murmur	□ Yes	□ No
Heart Problems/Attack	□ Yes	□ No
Hepatitis Type _____	□ Yes	□ No
Herpes	□ Yes	□ No
High Blood Pressure	□ Yes	□ No
Jaundice	□ Yes	□ No
Jaw Pain	□ Yes	□ No
Kidney Disease	□ Yes	□ No
Liver Disease	□ Yes	□ No
Low Blood Pressure	□ Yes	□ No
Mitral Valve Prolapse	□ Yes	□ No
Nervous Problems	□ Yes	□ No
Pacemaker	□ Yes	□ No
Psychiatric Care	□ Yes	□ No
Radiation Treatment	□ Yes	□ No
Respiratory Disease	□ Yes	□ No
Rheumatic Fever	□ Yes	□ No
Scarlet Fever	□ Yes	□ No
Shortness of Breath	□ Yes	□ No
Sinus Trouble	□ Yes	□ No
Skin Rash	□ Yes	□ No
Special Diet	□ Yes	□ No
Stroke	□ Yes	□ No
Swollen Feet or Ankles	□ Yes	□ No
Thyroid Problems	□ Yes	□ No
Tonsillitis	□ Yes	□ No
Tuberculosis	□ Yes	□ No
Tumor or growth on head or neck	□ Yes	□ No
Ulcer	□ Yes	□ No
Venereal Disease	□ Yes	□ No
Weight Loss, unexplained	□ Yes	□ No

WOMEN:

Are you pregnant?	□ Yes	□ No
Due Date_____		
Are you nursing?	□ Yes	□ No
Taking Birth Control Pills?	□ Yes	□ No

CONSENT

I attest to the accuracy of the information I have given and I understand that this information will be held in the strictest confidence. I understand that it is my responsibility to inform this office of any changes in my medical status and/or address.

I authorize Dr. Barberee and associates to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also understand the use of anesthetic agents embodies certain risks and hazards for the relief and protection from pain during the planned and additional procedures. I understand certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage, or even death.

I authorize the release of any information concerning my (or my child's) health care, advise, or treatment to another doctor or to insurance companies.

I have read and understand this entire page front and back prior to signing below.

_____

Patient **Date**

X_____

Person responsible for account if different from above

How did you hear about us? (Check all that apply)

□ Cross Timbers Phone Book
□Century Link Phone Book
□Empire Tribune Newspaper
□Referred by: □Friend □Family □Co-worker
Name_____
□Other_____
□KSTV Radio
□Tarleton Radio
□Office sign on Harbin Dr.
□Internet/Web site
□Postcard Mailers
□Care to Share Card

Robert Earl Barberee, BS, DDS, PC

140 South Harbin Dr
Stephenville, TX 76401
Phone 254-968-CARE Fax 254-968-0450
www.DrBarberee.com

OUR FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We are committed to providing you and your family with optimum dental care. Please understand that payment of your bill is considered part of your dental treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any dental treatment.

Payment is expected at the time of service:

We accept cash, checks, Visa, Mastercard, Discover, and Care Credit cards. If you have the need to carry your financial commitment over a period of time, we can assist you in obtaining financing.

Minor patients of divorced parents:

A divorce decree is a legal agreement binding only upon the two parties who made the agreement. Regardless of whom the judge deemed financially responsible for dental bills, the parent who brings the child to the office for dental treatment is responsible for payment at the time of service. The parents can settle the financial responsibilities between themselves. Do not ask us to do this for you.

Dental Insurance

We will accept your insurance as partial payment as a non-contracted out of network provider for you or your family's dental treatment provided you have the following:

1. Proof of insurance coverage.
2. An insurance policy submission form for each member of your family undergoing dental treatment with all required information completed.
3. An insurance plan/form that provides for assignment of benefits to our office.
4. Signature of the insured wherever necessary.
5. Proof that your deductible has been met.

If you do not provide us with this information you will be responsible for all charges. Under this arrangement, you are responsible for paying your co-pay, any non-covered portions, and any deductibles. In addition, if your insurance company does not pay for our services, you agree to pay for the services rendered.

Cancellation/No Show Policy:

Our goal is to provide accessible high quality care. In consideration of the time and in fairness to our other patients and providers; we require 24 hour notice when cancelling or rescheduling an appointment. We understand that life has unexpected changes, often times at the last minute. As such, after the second occurrence of a no show or late canceled appointment, there will be a $100 per hour fee. A nonrefundable deposit will also be required to reschedule the appointment which will be applied to the patient responsibility portion of the visit or retained for the cancellation fee if you fail show or provide inadequate cancellation notice. This office reserves the right to dismiss patients with excessive cancelled appointments.

Interest charges and Collection Agency

I understand payment is due in full at the time of service and there is a $30 charge for returned checks. I, the undersigned, understand and agree that there will be an interest charge of 1.5% per month of any past due account over thirty days. I also understand and agree that if I am in default of this agreement, my balance will be sent to a collections agency and I will be responsible for all costs incurred to collect my delinquent account. My increased balance will be calculated by dividing my current unpaid balance by (.75). In the event an attorney would be required, my unpaid balance would be divided by (.50). All collection charges shall be paid by the patient (or responsible party) and this office will not be held liable for any damage done to my credit rating.

I have read and understand this entire page prior to signing below.

Print Patient Name_____

X_____ Date _____
Person Responsible for Account

Robert Barberee DDS
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Stephenville, TX 76401
Phone 254-968-CARE Fax 254-968-0450
www.DrBarberee.com

PATIENT TESTIMONIAL AND MODEL RELEASE

For valuable consideration, receipt of which is hereby acknowledged, I agree as follows:

1. I hereby give and grant Robert Barberee, D.D.S. for your unlimited period of time (the "Term"), the right to use, publish, copyright, broadcast, reproduce, reuse, republish, or shorten for purposes of copy, my name, picture, portrait, likeness, and testimonial statement, throughout the world, in any and all media and types of advertising and promotion now known.
2. I agree that all photographs of me used and taken by Robert Barberee, D.D.S are owned by them and that they may copyright material containing the same. If I should receive any print, negative or other copy thereof, I shall not authorize its use by anyone else.
3. I agree that no advertisement or other material need to be submitted to me for approval and Robert Barberee, D.D.S shall be without liability to me for any distortion or illusionary effect resulting from the publication of my picture.
4. Nothing herein will constitute any obligation of the licensed party to make any rights set forth herein.
5. I further grant to Robert Barberee, D.D.S. the option, exercisable in their sole discretion, to use any filmed, photo or taped performance of me for internet, television, social media, and radio commercials on behalf of Advertiser. I understand that my agreements to the terms set herein are not a condition to my employment as a performer in any commercials.

□ YES, I agree to the above

□ NO, I do not agree to release my image, likeness or testimonial

_____ _____

Signature Patient Printed Name

Dental Career Center of Stephenville

140 South Harbin Drive
Stephenville, TX 76401

Phone: 254-968-CARE
Fax: 254-968-0450
www.DCCStephenville.com

Dr. Barberee's office is certified by the State of Texas as a teaching institution and provides a dental assisting program. This program requires it's students to observe/assist and learn hands on with procedures within our dental practice. To ensure that we maintain your loyalty and personal comfort, we would like to give you the opportunity to allow/decline the students ability to observe/assist during your dental visits. Your decision can also be changed at anytime in the future. Thank you for your understanding in providing you with exceptional individualized care.

Please check one:

_____ Accept

_____ Decline

_____

Patient's Name (Print)

_____

Signature of patient, legal guardian, or authorized representative

_____

Date

Robert Barberee DDS
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Stephenville, TX 76401
Phone 254-968-CARE Fax 254-968-0450
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Electronic and Confidential Communications Agreement

Patient Name: _____Date of Birth: _____

Use this form if you would like our dental practice to communicate with you other than at your primary phone number and /or address. Fill out this request in its entirety. Your request may affect our normal billing and payment procedure. Please specify your alternative method for handling payment.

I agree that the dental practice may communicate with me electronically at the email address below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling our office.

Email Address: _____

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures. I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name:_____

Signature: _____

Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment*

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

Print

Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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Patients with Insurance

Ins Co Name_____

Ins Co Address_____

Ins Phone_____

Group #_____

Group Name_____

Policy Holder Name_____

Relationship_____

Policy Holder B-day_____

Policy Holder SS#_____

Employer_____

Office Policy Regarding Insurance Payments

Our office accepts Preferred Provider Organization (PPO) insurance; however, as **our providers are non-contracted with ALL insurance companies, we are OUT of NETWORK with your plan.** We will gladly discuss proposed treatment and how it relates to your insurance. As a courtesy, we will process insurance claim forms to your primary insurance carrier on your behalf. If you are covered by more than one plan, you must establish coordination of benefits (COB) with both of your insurance plans, or your claim may be denied. We will not file a claim to your secondary carrier.

Please remember that dental insurance is designed to assist people to obtain dental care and rarely covers more than 1/3 to 1/2 of the total cost of service. There may be a deductible, copayment, frequency limitation, and an annual maximum benefit to be considered. We suggest all patients to be familiar with their insurance contract.

Most policies cover what they consider to be a "usual and customary fee." Their payment schedules are often based on "averages" or a percentage of "average." We try to keep our costs within an acceptable range, at the same time providing above average treatment. We cannot lower our standards of treatment to your insurance company's standard of payment.

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Insurance Disclaimer: A quote of benefits does not guarantee payment or verify eligibility. Payments of benefits are subject to all terms, conditions, limitations, and exclusions of your insurance contract at time of service.

Insurance is a contract between yourself, your employer (if it is a group policy), and the insurance company. Our office does not make any decisions regarding your insurance eligibility, benefits, or final payment. Our main concern is your dental health, comfort, and appearance. Under this arrangement with our office, you are responsible for paying your co-pay, any non-covered portions, and any deductibles on the date of service. In addition, if your insurance company does not pay for our services, you agree to pay for the services rendered.

As a courtesy, we will wait up to 60 days for your insurance payment. Our office shall carry no balance (including insurance billings) for more than 60 days. If your insurance company has not paid within 60 days, you must pay your balance with Cash, Check, or Credit Card.

X_____ **Date**_____

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www.DrBarberee.com

HIPAA Authorization for Release of Patient Health Information

I consent and authorize the release of PHI to the following (check all that applies):

☐ Only Myself
☐ My Spouse: _____
☐ My Children: _____
☐ My Parents: _____
☐ Other: _____

I consent and authorize the release of financial information to the following (check all that applies):

☐ Only Myself
☐ My Spouse: _____
☐ My Children: _____
☐ My Parents: _____
☐ Other: _____

By signing below, I am giving permission to share my patient health information with non-covered entities as indicated above. I understand that this authorization will remain in effect until revoked in writing.

_____ _____
Print Patient Name **Date**

_____
Patient / Guardian Signature