

# Confidential Patient Information

## BARBEE DENTAL

Kelli A. Barbee, DMD, 1830 Destiny Lane, Ste. 119, Bowling Green, KY 42104, (270)393-9925 fax (270)393-9928

(Please Print Legibly)

Date: \_\_\_\_\_

### PERSONAL INFORMATION

Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

(Cell) \_\_\_\_\_ e-mail: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

Primary Insurance Co: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Employee: \_\_\_\_\_ Relationship: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Employee: \_\_\_\_\_ Relationship: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy #: \_\_\_\_\_

***I understand that payment is my obligation regardless of insurance or any other third-party involvement.***

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# Confidential Patient Information – II

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(Please Print Legibly)

Patient Name: \_\_\_\_\_ Initial Date: \_\_\_\_\_

## HEALTH INFORMATION

Personal Physician Name: \_\_\_\_\_

Personal Physician Address: \_\_\_\_\_

YES NO

1. Have you been hospitalized within the past 2 years? For what? \_\_\_\_\_
2. Are you currently being treated by a physician? For what? \_\_\_\_\_
3. Are you currently taking any medicines or drugs? What? \_\_\_\_\_

4. Have you ever received counseling for excessive use of alcohol and/or prescription drugs? \_\_\_\_\_
5. Are you allergic to any drugs? What? \_\_\_\_\_
6. Have you ever had a skin rash or other reaction to metal jewelry? To What? \_\_\_\_\_
7. Are you allergic to any metals? What? \_\_\_\_\_
8. Do you bleed excessively upon injury? \_\_\_\_\_
9. Are you pregnant? \_\_\_\_\_
10. Have you ever been involved with dental/medical legal activity? \_\_\_\_\_
11. Do you use tobacco? \_\_\_\_\_

## CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD OR NOW HAVE

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatment
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/ Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problem	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble/Disease	Psychiatric Care	Venereal Disease
			Yellow Jaundice

## PERSON TO BE CONTACTED IN CASE OF EMERGENCY (OTHER THAN RELATIVE)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

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: \_\_\_\_\_

REVIEW BY: \_\_\_\_\_ DATE: \_\_\_\_\_

\*If you circled either I or T describe condition:

\_\_\_\_\_

\_\_\_\_\_

# Request and Consent for Dental Treatment

J. Scott Barbee D.M.D. Kelli Barbee D.M.D.

Please read this form *carefully!* If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it!

1. I request and authorize the dental treatment and associated procedures for:

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

2. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.
3. I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s).
4. **I understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be **safely** provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements.
5. **I further understand** that should the patient become uncooperative during dental procedures with excessive body movements, the patient may need to be wrapped in a "hug blanket" or "papoose board" to prevent injury and enable Dr. Barbee to **safely** provide the necessary treatment.
6. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.
7. I have had explained to me by Dr. Barbee and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

Over

Initials \_\_\_\_\_

8. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.
9. **I understand** that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's TREATMENT PLAN and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in the office.
10. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the TREATMENT PLAN.
11. **I understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
12. I request and authorize the dental treatment and associated procedures outlined on the TREATMENT PLAN.
13. **I confirm** that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

\_\_\_\_\_  
Signature of Person Consenting to Treatment

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dr. Barbee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Certification

\_\_\_\_\_  
Date

BARBEE DENTAL

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\*You may refuse to sign this acknowledgement\*

I, \_\_\_\_\_, have received or been offered a copy of the Barbee Dental Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

(Note: Please add this signed form to the "Consent" Section of the standard record or enclose in the emergency patient record)

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For Office Use Only

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We attempted to obtain written acknowledgement of receipt of Barbee Dental 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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Approved by Administrative council 12/13/02

Approved by OGC: 02/04/03

**BARBEE DENTAL**  
**J. Scott Barbee, D.M.D., P.S.C.**  
**1830 Destiny Lane, Suite 119 • Bowling Green, KY 42104**  
**(270) 393-9925 Voice • (270) 393-9928 fax**

**FINANCIAL RESPONSIBILITY AGREEMENT**

This Agreement is entered into between J. Scott Barbee, D.M.D., P.S.C. ("Barbee Dental") and the Parent/Guardian/Responsible Party ("Responsible Party") identified below.

1. **Time When Payment Is Due:**

Payment for all services rendered by Barbee Dental is due at the time that care is provided, except in those instances where pre-payment is required.

2. **Effect of Receiving Treatment:**

By accepting treatment from Barbee Dental, you represent and acknowledge as follows:

- a. that you have legal authority to consent to treatment on behalf of the patient;
- b. that you are authorizing Barbee Dental to render all necessary or beneficial treatment, as determined in Barbee Dental's professional judgment (including determinations made by licensed members of Barbee Dental's office staff);
- c. that Barbee Dental's charges are presumed to be reasonable and appropriate for the services rendered; and
- d. that you are accepting legal responsibility for paying all charges in full in accordance with this agreement.

3. **Scheduling Changes:**

Scheduling changes or cancellations must be made at least 24 hours in advance. Failure to advise Barbee Dental of scheduling changes or cancellations in accordance with this agreement will result in your being charged for a missed appointment.

4. **Assistance with Insurance Claims:**

Upon request, we will assist you in obtaining an estimate of benefits payable by your insurance company (dental & medical). Regardless of any action taken by your insurance company, you will be responsible for paying Barbee Dental's charges in full in accordance with this agreement.

5. **Recovery of Collection Expenses:**

You agree, in order for us to service your account, notify you of information pertaining to your account or medical condition, or for the purposes of collections, we may contact you by telephone at any number provided by you, including wireless telephone numbers. We may also contact you via email or text message using any email address you provide. Methods of contact may include the use of pre-recorded and artificial voice messages and/or use of an automated dialing device. You agree that if this account is not paid when due, and Barbee Dental should retain an attorney or collections agency for collections, YOU AGREE TO REIMBURSE US THE COLLECTION FEES OF ANY COLLECTION AGENCY, WHICH SHALL BE BASED ON A PERCENTAGE AT A MAXIMUM RATE OF 33 1/3% OF THE AMOUNT DUE AT THE TIME YOUR ACCOUNT IS PLACED WITH A COLLECTION AGENCY, AND ALL COSTS AND EXPENSES INCURRED FOR ANY COLLECTION EFFORTS ON YOUR ACCOUNT, INCLUDING REASONABLE ATTORNEY'S FEES INCURRED BY THE COLLECTION AGENCY. THIS CONTRACT SHALL COVER ALL MEDICAL TREATMENT AND SERVICES UNTIL REVOKED BY EITHER PARTY IN WRITING.

**PLEASE DO NOT SIGN THIS AGREEMENT UNTIL YOU HAVE READ AND UNDERSTOOD IT.**

\_\_\_\_\_  
Parent/Guardian/Responsible Party

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

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## Policies for our Patients with Insurance

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Parent's Name \_\_\_\_\_

**Welcome to our office!** We are pleased that you have chosen us to take care of your child's dental needs. To make our time together most efficient and enjoyable, we have listed several office policies.

**Please read them carefully.**

1. *Be on time for your appointment.* If you are more than 10 minutes late, you risk cancellation of your appointment and inactivation of care.
2. *Bring your current KY Medicaid Card or Insurance card to every appointment. We cannot treat your child without a current Medicaid card at the time of each visit.* If you do not present a current card, you risk the appointment being considered missed and to be inactivated.
3. *Inform us of change in your eligibility.* You will be billed if you are not eligible. **It is also your responsibility to inform us of any change of address or phone number.**
4. *Due to the amount of paperwork and office time to process Insurance claims, we will file your insurance for payment one time.* If your insurance denies payment, pays less than estimated or has changed, you become responsible for payment of any remaining balance.
5. *If your dental treatment plan includes the need for hospital facility and anesthesia, you will be charged and billed separately from the hospital.* We will approve your health insurance for coverage, but we are not able to estimate the hospital and anesthesia charges.
6. **A BROKEN APPOINTMENT MAY RESULT IN OUR NOT SCHEDULING FOR YOUR CHILD'S FUTURE TREATMENT.**
7. *A 24-hour notice must be given for cancellation of an appointment, or it will be considered a broken appointment.* Telephone voice-mail is available 24 hours a day.
8. Patients who cannot be contacted by the telephone or mail service for over 12 months may be inactivated.

These policies are for the benefit of everyone. If you have any questions, please ask our office staff.

Thank you,

Drs. Barbee and Staff

I have read and understand the above policies.

Signature \_\_\_\_\_  
Relationship to child \_\_\_\_\_ Date \_\_\_\_\_