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

Pediatric Dentisty of Bowling Green

1830 Destiny Lane • Suite 119 • Bowling Green, KY 42104 • Telephone: (270) 393-9925 • FAX: (270) 393-9928

Demographic Information

Patient_____________________________ Today's Date__________

Name child would like to be called_______________Home Phone__________

Birthday__________ Age______ Sex______ Cell Phone__________

Patient's SS# __________Parent/Guardian's Email __________

Home Address____

street *town* *state* *zip code*

School_____________________________ Grade __________

Parent/Guardian 1: ______________Relation to patient__________

DOB __________ SS#__________ Marital Status __________

Employer_____________________________Phone__________

Parent/Guardian 2: ______________Relation to patient__________

DOB __________ SS# __________ Marital Status __________

Employer _____________________________Phone__________

Who has legal custody of patient?__________Dental Insurance Company ______

Name of child's physician/group__________City/St__________Ph #__________

Whom may we thank for referring you to us?__________________

What is the reason for your child's dental visit?__________________

Names and ages of other children in family __________________

Health History

☐ Yes ☐ No Is your child in good health? Date of last physical exam__________

☐ Yes ☐ No Has your child ever had a health problem?__________

☐ Yes ☐ No Has your child ever been hospitalized? Please give reason and dates______

____

☐ Yes ☐ No Is your child allergic to anything?__________

☐ Yes ☐ No Is your child currently taking any medications? Please give medication, dose and reason__________

☐ Yes ☐ No Were there any problems at birth?__________

☐ Yes ☐ No Any history of alcohol, tobacco or substance abuse? __________

☐ Yes ☐ No Is your child taking birth control or pregnant? __________

Please indicate if your child has been treated for any of the following:

☐ Heart disease	☐ Bleeding/transfusions	☐ Asthma/breathing	☐ Blood dyscrasias
☐ Liver/GI disease	☐ Anemia	☐ Diabetes	☐ AIDS
☐ Kidney disease	☐ Rheumatic fever	☐ Hepatitis	☐ Mental delays
☐ Speech/hearing	☐ Seizures	☐ Cleft lip/palate	☐ Physical delays
☐ Eyesight	☐ Congenital birth defects	☐ Personality/social	☐ Other problems
☐ Cancer/tumors	☐ Recurrent headaches	☐ Frequent infections	☐ Adverse Drug reations
☐ Cerebral palsy	☐ Significant injuries	☐ Endocrine/growth	☐ Autism __________

____

Do you consider your child to be
- ☐ advanced in the learning process
- ☐ progressing normally
- ☐ slow in the learning process

Was your child , ☐ breast fed ☐ bottle fed at what age was it stopped?________

Dental History

☐ Yes ☐ No Has your child ever been to the dentist? Date of last xrays (if taken)________
Name of dentist and date________________________________

☐ Yes ☐ No Has your child experienced any unfavorable reaction from previous dental care? Explain________________________________

☐ Yes ☐ No Does your child suck a finger, thumb or pacifier?

☐ Yes ☐ No Does your child have pain with chewing, yawning, or wide opening?

☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Toothache	☐ Teeth Sensitive
☐ Trauma	☐ Gum Infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: ________________________________

____

Fluoride History

Office Use Only
- ☐ Fl- City Water
- ☐ Pvt. Well
- ☐ Public Well ______ppm
- ☐ H_2O test kit given

☐ Yes ☐ No Is your home water supply fluoridated?

☐ Yes ☐ No Does your child use a fluoride toothpaste?

☐ Yes ☐ No Do you give your child any other form of fluoride? What?____________

☐ Yes ☐ No Does your child participate in a school fluoride rinse program?

Consent for Dental Treatment

I request and authorize Dr. Barbee to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Barbee to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Barbee will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature ________________________________ **Date** ____________

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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Consent for Dental Treatment and/or Care of a Minor Child

We realize that parents or legal guardians may not always be able to personally accompany their child to our office. However, Kentucky law dictates that a patient under the age of 18 CANNOT be treated without a parent or guardian's consent. To ensure that your child may receive prompt dental care, please complete the following form/information.

I ____ of ____________________________________
Parent/ Legal Guardian   Child

A minor born on _________________________ who resides with me at

____
Address

Do hereby give consent for the following person or persons to request and authorize dental treatment for my child.

Authorized Party	Relationship
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

The above person(s) have my permission to receive dental information and to make dental decisions on behalf of my child.

Signature ____ Date_________________

BARBEE DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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)

For Office Use Only

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)

____
____
____
____
____

Approved by Administrative council 12/13/02
Approved by OGC: 02/04/03

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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 ______________

Parent Release Form for Media Recording

I, the undersigned, do hereby grant permission to Barbee Dental to use the image of my child, ______________________________, as marked by my selection below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the Barbee Dental/ Pediatric Dentistry of Bowling Green Web site, Face Book and/or Twitter.

□ **Unrestricted usage:** I give unrestricted permission for my child's image to be used in print, video, and digital media. I agree that these images may be used by Barbee Dental for a variety of purposes and that these images may be used without further notifying me. I do understand that the child's last name will not be used in conjunction with any video or digital images.

Parent/Guardian signature ______________________________ Date__________

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