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: ____________

Patient Health History
Dr. Kelli Barbee

Name ______________________ Date of Birth __________ Today's Date ________

Are you under the care of a physician? Yes No

If yes, Physician's name ____________________ Condition(s) being treated ______________

Have you had a serious illness, operation or been hospitalized? Yes No

If yes, what was the illness or problem ______________________________

Please list all medications you are taking, including vitamins or supplements:

____

____

Have you had any joint replacements (hip, knee, elbow, finger) Yes No ________ Date ________

Do you use: Controlled Substances Yes No Tobacco Yes No Alcoholic Beverages Yes No

Has a physician or previous dentist recommended that you take antibiotics prior to dental Treatment Yes No What for? ________________

If yes, name and phone number of physician/dentist __________________________

Are you taking or scheduled to begin taking any medications for osteoporosis or Paget's disease? Yes No If yes, what is the name of the medication you are taking? ________________

Since 2001, were you treated or are you presently scheduled to being treatment, with any intravenous bisphosphonates for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, osteogenesis imperfecta, multiple myeloma or metastatic cancer? Yes No If yes, what is the name of the medication and date treatment began or scheduled to begin ______________________

Are you allergic to or have you had any reactions to:

Aspirin Yes No
Animals Yes No
Barbiturates, sedatives or sleeping pills Yes No
Codeine Yes No
Food Yes No ____________________
Hay fever/seasonal allergies Yes No
Iodine Yes No
Latex (rubber, kiwi, banana) Yes No
Local anesthetics Yes No
Metals Yes No
Penicillin Yes No
Other antibiotics Yes No __________
Sulfa Drugs Yes No
Other Yes No ______________

WOMEN ONLY. Are you:

Pregnant YES NO Nursing YES NO Taking birth control pills/hormones YES NO

Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve	Yes	No	Congenital heart disease/defect	Yes	No
Previous infective endocarditis	Yes	No	Unrepaired, cyanotic CHD	Yes	No
Damaged valves in heart	Yes	No	Repaired(completely) in last 6 mon	Yes	No
Repaired CHD with residual defects	Yes	No			

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

ADHA
AIDS or HIV
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Artificial Joint
Arthritis/Rheumatic Arthritis
Asthma
Autism
Autoimmune Disease
Blood Disease
Cancer/Chemotherapy/Radiation
Cardiovascular Disease
Cold Sores/Fever Blisters
Congestive Heart Failure
Diabetes I or II
Drug Addiction
Eating Disorder or Malnutrition
Emphysema
Epilepsy/Seizures
Fainting/Dizziness
Heart Attack
Heart Murmur
Hemophilia
Hepatitis/Jaundice/Liver Disease
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Low Blood Pressure
Mental Health Disorders
Mitral Value Prolapse
Neurological Disorders
Nightsweats
Osteoporosis
Pacemaker
Pain in Jaw Joints
Reflux/Persistent Heartburn
Rheumatic Fever
Rheumatic Heart Disease
Severe Headache/Migranes
Severe or Rapid Weight Loss
Sexually Transmitted Disease
Sleep Disorder
Stroke
Systemic Lupus
Thyroid Problems
Tuberculosis
Tumors or Growths
Ulcers

Do you have any disease, condition, or problem not listed above that you think I should know about?

YES NO If yes, please explain ________________________________

PERSON TO BE CONTACTED IN CASE OF EMERGENCY

Name ________________________ Relationship ________________ Phone Number _______________

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/patient's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Legal Guardian __________________________________

Reviewed by __________________________ 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

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

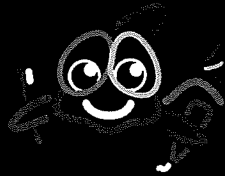
Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (please specify)

____
____
____
____
____

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



Barbee
DENTAL
PEDIATRIC & FAMILY DENTISTRY

J. Scott Barbee, DMD
Board Certified Pediatric Dentist
1830 Destiny Lane, Suite 119
Bowling Green, KY 42104
Phone: 270.393.9925
www.BarbeeDental.com

I, ____, give consent to the following people to discuss my treatment and/or payment with the team members at Barbee Dental.

____

____

____

____

Signature ____ Date ___________________________

BARBEE DENTAL

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(270) 393-9925 • fax (270) 393-9928

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 ____________

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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:______________________________