

Duane H. Beers, D.M.D., P.C.

Cosmetic and Laser Dentistry
Master-Academy of Laser Dentistry



Date: _____

Child's Information:

Name: _____ Nickname: _____
Last First MI

Date of birth: _____ Male Female Phone: _____

Address: _____
Street Apartment #
City State Zip Code

Favorite: Sport: _____ Toy: _____ Hobby: _____
Person: _____ Fictional Character: _____

Parent's Information:

Father's name: _____ SSN: _____ DOB _____
Last First MI

Employer: _____ Work Phone _____ Dental Ins: Yes No

Mother's name: _____ SSN: _____ DOB _____
Last First MI

Employer: _____ Work Phone _____ Dental Ins: Yes No

Whom may we thank for referring you to our practice? Friend Relative _____

Child's Dental History

Date of last dental visit: _____ For what service: _____

	Yes	No		Yes	No
Has child complained about dental problems?	<input type="checkbox"/>	<input type="checkbox"/>	Does your child brush teeth daily?	<input type="checkbox"/>	<input type="checkbox"/>
Any unhappy dental experiences?	<input type="checkbox"/>	<input type="checkbox"/>	Do you assist child with tooth brushing?	<input type="checkbox"/>	<input type="checkbox"/>
Any injuries to mouth- teeth- head?	<input type="checkbox"/>	<input type="checkbox"/>	How often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits-thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, ect	<input type="checkbox"/>	<input type="checkbox"/>	Is dental floss used?	<input type="checkbox"/>	<input type="checkbox"/>
Any unusual speech habits?	<input type="checkbox"/>	<input type="checkbox"/>	How often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any lost teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Are disclosing tablets used?	<input type="checkbox"/>	<input type="checkbox"/>
Have missing teeth been replaced?	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride used in any form?	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontic appliances worn now or ever?	<input type="checkbox"/>	<input type="checkbox"/>	Do you desire complete dental service for the child?	<input type="checkbox"/>	<input type="checkbox"/>
			Child's attitude toward dentistry	_____	

Child's Health History

Child's physician: _____ Address: _____ Phone: _____
Date of last physical exam: _____

Please complete the next 2 pages →

	Yes	No		Yes	No
Is child under care of a physician now?	<input type="checkbox"/>	<input type="checkbox"/>	Does child have good physical coordination?	<input type="checkbox"/>	<input type="checkbox"/>
Is child receiving any medication or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Are there any emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>

Is there any excessive bleeding when cut?	<input type="checkbox"/> <input type="checkbox"/>	Is there any allergy to penicillin or other drugs?	<input type="checkbox"/> <input type="checkbox"/>
Has child ever been hospitalized?	<input type="checkbox"/> <input type="checkbox"/>	Are there other allergies: food, pollen, animals-	<input type="checkbox"/> <input type="checkbox"/>
Has child ever had surgery?	<input type="checkbox"/> <input type="checkbox"/>	Please list:	
Please explain:			

Has child had any history of or difficulty with any of the following:

- | | | | | |
|---|--|---------------------------------------|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic sinus | <input type="checkbox"/> Hearing | <input type="checkbox"/> Mastoid | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Rheumatic fever | |

Please describe any conditions, injuries, or pending surgeries that may need to be brought to our attention:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in the child's health, I will inform the doctor at the next appointment without fail.

Signature of parent or guardian

Relationship to child

Date

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date _____ ID# : _____ Group #: _____

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Insurance Plan Name and Address: _____

Our office is happy to file your insurance claim for you, however we do require that you agree to the following terms of service:

1. I understand and agree that the amount estimated to remain unpaid by insurance is to be paid by me at the time of treatment.
2. I understand that this office cannot make a totally accurate estimate of the insurance benefits to be paid for me, since it does not have access to all insurance company records.
3. I understand that if upon payment by the insurance company there is a remaining balance, it is due to be paid in full by me at that time.
4. I understand that my insurance policy is a contract between me and my insurance company, and that Duane H. Beers, D.M.D., P.C. is not a part of that contract, I further understand that if my insurance company has not paid my account in full within 60 days, the balance of my account is due by me immediately.

I agree to the terms of service and I authorize the release of any information necessary to process my insurance claim.

Signature _____ Date _____

I authorize payment to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original.

Signature _____ Date _____ Consent for Services

As a condition of your treatment by this office, **payment is due at time of service.**

Consent for Services

As a condition of your treatment by this office, **payment is due at time of service.**

All dental services, including emergencies, must be paid for with cash, check, or credit cards at the time of service.

Patients who carry dental insurance understand that **all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services.** As a courtesy, this office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an

insurance company. Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 30 days, the balance of your account is due by you immediately.

Payment options include the following:

1. Cash or check at time of service. (Fee reduction of 5% is available if payment for treatment is made in full prior to treatment).
2. Credit Card (MasterCard, Visa, Discover, and American Express)
3. Wells Fargo Preferred Customer Account- 12 months interest free loan. Ask for more details.
4. Care Credit- a low interest loan for larger balances and longer payment schedules. Ask for more details.

For payment planning purposes we have the right to investigate your credit history, verify your credit references, and to report the way you pay your account to credit bureaus and other interested parties.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days. When accounts have exceeded 90 days we reserve the right to report the account to a collection agency.

I, consent to the performing of the agreed upon dentistry, which is deemed to be necessary or advisable, in the opinion of the Doctor, as outlined in the treatment plan.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days.

In consideration for the professional services rendered to me, I agree to pay the reasonable value of services to the Doctor, at the time services are rendered. I further agree that the reasonable value of services shall be as billed.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient:

Signature of guarantor of payment/responsible party

I, _____, authorize the use of my study models, x-rays, and "before and after" photographs to be used in photo albums, lectures, web sites, and publications by Duane H. Beers, D.M.D.

Consent For Use and Disclosure of Health Information

TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Practices before you decided whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Duane H. Beers D.M.D., P.C.

Telephone: (575)835-3662 Fax: (575)838-1631

E-mail: drbeers@sdc.org Address: 200 Manzanaras Ave, Socorro, NM 87801

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____