

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

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 my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian _____

Dental Health and Appearance

Reason for visit: _____ Approximate date of last dental visit: _____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth? _____ How often do you floss (routinely)? _____

What type of brush do you use? SOFT MED HARD

Do you avoid brushing any part of your mouth because of pain? Yes No . If yes, what part? _____

Which foods cause you twinges of pain: hot cold sweet sour none

Do you lose or break fillings? Yes No

Do you chew on only one side of your mouth? Yes No If yes, explain: _____

Do your gums feel tender or swollen? Yes No

Do you usually have many cavities? Yes No

Do you clench or grind your jaws while sleeping or during the day? Yes No

Do your jaws ever feel tired? Yes No

Do you have missing teeth? _____ If yes, have you had them replaced? _____

Are you happy with the results? _____

Have you ever had any serious problem associated with previous dental treatment? Yes No

Is so, explain: _____

Insurance Information

Insurance Plan Name and Address: _____

Phone: _____

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

Last First MI

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

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

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.

Signature _____ Date _____

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.**

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@sdcc.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.

Signature _____ Date _____

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

Personal Representative's Name: _____ Relationship to Patient: _____