Phone: 770.925.3300 | TeboDental.com

TEBO DENTISTRY FOR KIDS	TEBO DENTISTRY FOR TEENS	TEBO DENTISTRY FOR KIDS	TEBO DENTISTRY FOR KIDS
LILBURN	LILBURN	GAINESVILLE	DACULA
609 BEAVER RUIN ROAD NW SUITE B	609 BEAVER RUIN ROAD NW SUITE B	3535 THOMPSON BRIDGE ROAD	1152 AUBURN ROAD SUITE 101
LILBURN, GEORGIA 30047	LILBURN, GEORGIA 30047	GAINESVILLE, GEORGIA 30506	DACULA, GEORGIA 30019

HEALTH HISTORY UPDATE

Guardian's Name ____________ D.O.B. ___/___/___ Social Security # ____________ Relationship To Patient ____________

Today's Date ____________ Email Address ____________

Phone Numbers Primary # ____________ Secondary # ____________

Address ____________
Street or PO Box Apt./Suite/Unit # City State ZIP

What is your preferred method of contact? ☐ Email ☐ Cell ☐ Work ☐ Home ☐ Text Message

Patient's Name ____________ D.O.B. ___/___/___

☐ No Changes To Insurance Information (Skip Insurance Section)

Dental Insurance ____________ Subscriber's Name ____________

Insurance Phone # ____________ Subscriber's S.S.# ____________ Group / Plan # ____________

Please List All Current Medications ____________

Please List Current Allergies & Reactions ____________

Preferred Language ☐ English ☐ Spanish Member ID: ____________

Please indicate if your child has or has had any of the following:

☐ Asthma	☐ Nosebleeds	☐ Emotional Problems Oral	☐ Allergies
☐ Egg Allergy	☐ Kidney diseases/conditions	☐ Habits	☐ Psychological Issues
☐ Soy Allergy	☐ Premature Birth	☐ Sickle Cell	☐ Seizure Disorder
☐ Past Surgery (if so, please explain) ____________	☐ Heart Conditions (if so, please explain) ____________	☐ Speech Therapy	☐ Mouth Sores/Ulcers
			☐ Hospitalization

Are there any questions about your child's dental health that we can answer today?
____

What current medications is your child on?
____

Additional Family Member

Patient's Name ____________ D.O.B. ___/___/___

☐ No Changes To Insurance Information (Skip Insurance Section)

Dental Insurance ____________ Subscriber's Name ____________

Insurance Phone # ____________ Subscriber's S.S.# ____________ Group / Plan # ____________

Please List All Current Medications ____________

Please List Current Allergies & Reactions ____________

Preferred Language ☐ English ☐ Spanish Member ID: ____________

Please indicate if your child has or has had any of the following:

☐ Asthma	☐ Nosebleeds	☐ Emotional Problems Oral	☐ Allergies
☐ Egg Allergy	☐ Kidney diseases/conditions	☐ Habits	☐ Psychological Issues
☐ Soy Allergy	☐ Premature Birth	☐ Sickle Cell	☐ Seizure Disorder
☐ Past Surgery (if so, please explain) ____________	☐ Heart Conditions (if so, please explain) ____________	☐ Speech Therapy	☐ Mouth Sores/Ulcers
			☐ Hospitalization

Are there any questions about your child's dental health that we can answer today?
____

What current medications is your child on?
____

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Appointment and Payment Agreement

The undersigned agrees to pay all charges related to the treatment of the patient at the offices of Tebo Dental Group and agrees to the terms and conditions stated below. If two or more persons are responsible for charges, then all responsible persons shall be jointly and severally liable for the patient's charges.

Missed or canceled appointments

If an appointment needs to be canceled, please notify us at least 24 hours or 1 business day in advance of the appointment. Appointments scheduled on Mondays must be canceled prior to the time of the scheduled appointment on the preceding Friday or the appointment will be considered a Broken Appointment. Our office hours are Monday through Friday from 8:00 am to 5:00 pm. While we do not charge a Missed Appointment Fee for canceled or missed appointments, we do stand firmly behind our missed appointment policies in an effort to offer the best possible experience for our patients who make it on time for their appointments.

Payment is due at the time of treatment

Payment for treatment is due in full at the time of treatment, unless you have made other payment arrangements with us. If we are filing an insurance claim for you, please read the next section for an explanation of payment arrangements. We offer 3rd party financing in the event the patient cannot pay for the treatment in full. Ask staff member for details.

Insurance claims

If we file an insurance claim for the patient, you will need to pay us at the time of treatment the expected insurance deductible and any amount that we expect insurance will not cover. We try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charges, whether or not the insurance company provides any coverage. If your insurance company does not pay on the claim within 30 days from the date of service, the balance is the sole responsibility of the patient.

Returned checks

We charge $30.00 for any check that is returned to us without payment. Also, if you have given us a bad check in the past, we will not accept a personal check from you in the future as payment for dental services.

Interest on late payments

Please pay all charges on time. We charge interest at the rate of 1.5% per month for charges not paid within 30 days. We recommend patients understand their insurance benefits and monitor their plans for prompt payment.

Collection costs

We will charge the patient's account for our collection costs if we refer the account to an outside agency or attorney for collection. These costs include the collection agency's commission and, if an account is collected after the start of a collection lawsuit, reasonable attorneys' fees and expenses and court costs. For accounts referred to a collection agency, we will add 43% to the principal amount due so that the office will be left with the full principal amount after deducting the collection agency's commission from the amount collected.

Consent to Disclosures concerning Treatment or Charges

If we try to contact you concerning the patient's treatment or charges and reach instead someone we believe to be directly involved in the patient's care, such as your spouse, another family member, other relative or close personal friend, you consent to our disclosure to that person of any information our office finds appropriate concerning treatment or charges for the patient. If the patient is covered by insurance, you also consent to the disclosure of information related to the patient's treatment or charges to the policyholder or person primarily insured under the policy.

X______________________________________ Date signed:______________________________

Signature of person responsible for charges

Name of signer:__________________________ Name of patient:__________________________

Relationship of signer to patient (if self, so state): ______________________________

*If the signer is not the patient and is not the patient's HIPAA personal representative (i.e. a custodial parent, guardian or other person authorized to act on behalf of the patient in making health care decisions), then the patient (if an adult) or the patient's personal representative should sign a separate Appointment and Payment Agreement or an Authorization to Release Information to Third Party (contained in the office's Privacy Policies), to authorize the disclosures described above concerning treatment or charges.

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Authorization for Caregiver to Act for Parent or Guardian

Child's name: ______________________________ Date of birth: ______________________

Child's name: ______________________________ Date of birth: ______________________

Child's name: ______________________________ Date of birth: ______________________

Child's name: ______________________________ Date of birth: ______________________

Caregiver's name: _________________________________ Phone: ______________________

Relationship of caregiver to children: ____

Caregiver S.S. #:______________ D.O.B.:__________ Address:___________________________

I, the undersigned parent or guardian of the children named above (or child, if just one), entrust the care of the children to the caregiver named above during any present or future visit to any office of Tebo Dental Group. The purpose of this Authorization is to permit the children to receive dental treatment when I cannot be present in person. I understand that only adults (18 or older) may act as caregivers under this Authorization.

The caregiver has the power and authority, on my behalf:

- to receive and disclose all health information, and to make all decisions, related to the dental treatment of the children at any office of Tebo Dental Group;
- to execute in my name any consent to treatment and any other consent or document relating to the exercise of the powers and authorities granted in this Authorization;
- to commit me to pay all charges for dental treatment to which the caregiver consents; and
- to perform any other act necessary or appropriate to the exercise of powers and authorities granted by this Authorization as fully as I could do if present in person.

Every act the caregiver lawfully does pursuant to this Authorization shall be binding on me. I understand that I will be liable for all charges for dental treatment to which the caregiver consents pursuant to this Authorization.

This Authorization shall remain in effect until completion of dental treatment of the child(en) at any office of Tebo Dental Group or until I revoke this Authorization as provided below.

I understand that I have the following rights: I can revoke this Authorization at any time by giving my oral or written revocation to the office of Tebo Dental Group at which my children are being treated. My revocation will not be effective for any disclosures already made or any actions already taken in reliance on this Authorization. Tebo Dental Group may not condition treatment, enrollment in any health plan or eligibility for any benefits on whether or not I sign this Authorization. I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and may no longer be protected by federal law. I have received a copy of this Authorization.

I HAVE READ AND I UNDERSTAND THIS AUTHORIZATION.

X____ Date signed: ____________________

Signature of parent or guardian

Printed name: ______________________________ Phone: ________________________

Rev 2012-06