TEBO DENTAL

Phone: 770.925.3300 | TeboDental.com

Health History Update

Name _____ 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 methof 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 _____ Member ID _____

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

Please List All Current Medications _____

Please List Current Allergies & Reactions _____

Preferred Language ☐ English ☐ Spanish

If any changes have occurred in the following list, please check its box and correct it below.

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

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

_____

Additional Family Member

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

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Dental Insurance _____ Subscriber's Name _____ Member ID _____

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

Please List All Current Medications _____

Please List Current Allergies & Reactions _____

Preferred Language ☐ English ☐ Spanish What is your child's tobacco use? ☐ Daily ☐ Occassional ☐ None

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Appointment and Payment Agreement

The terms of this Agreement apply to all locations of Tebo Dental Group ("we", "us", "our offices" or words to that effect), including Tebo Dentistry for Kids Lilburn, Tebo Dentistry for Teens, Tebo Dentistry for Kids Gainesville, Tebo Dentistry for Kids Dacula and Tebo Dentistry for Kids Peachtree Corners, Tebo Orthodontics Lilburn, Tebo Orthodontics Dacula, Tebo Orthodontics Peachtree Corners, and to any future dental offices that Tebo Dental Group may open.

Our charges
You (the undersigned) agree to pay all charges related to our treatment of the patient named below and agree to the terms and conditions of this Agreement. These charges include any applicable interest and collection costs and fees for appointments that are broken or cancelled without the advance notice described below. If two or more persons are responsible for the patient's charges, then all responsible persons are jointly and severally liable for such charges.

Refunds
If you are due a refund, we will issue the refund in the same form as your original payment. For example, if you paid by credit card, we will issue a refund to the same credit card. As another example, if you paid with funds from a Flexible Savings Arrangement (FSA) account, we will issue a refund to the same FSA account. If we are unable to issue a refund in the same form as your original payment, we will issue a refund in any form we choose in our reasonable discretion.

Missed or canceled appointments
If you need to cancel an appointment, please notify us at least one (1) full weekday in advance of the appointment. For example, please notify us by 9:00 am Friday to cancel an appointment scheduled for 9:00 am the following Monday. We may charge $50.00 for each missed or canceled appointment if we do not receive the required advance notice. To cancel an appointment, please call and talk to us during office hours, Monday through Friday from 8:00 am to 5:00 pm.

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. If you cannot afford to pay our charges in full, please ask our staff about any available third-party financing.

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 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 must pay us the remaining balance if the insurance company does not pay the claim for our charges within thirty (30) days after the date of service.

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 services.

Interest on late payments
Please pay all charges on time. We add interest at the rate of 1-1/2% per month to any charges not paid within thirty (30) days after the date of service. This applies to any charges that the patient's insurance company fails to pay on time. Please monitor the patient's insurance plan to make sure that the insurance company pays the patient's charges promptly.

Collection of past due accounts by collection agency or attorney
If the patient's account is not paid when due and we refer the patient's account to a collection agency or attorney for collection, we will charge the patient's account the amount we must pay to the collection agency or attorney to collect your account. Collection agencies typically charge a percentage commission, ranging from 30% up to 50% of the total amount collected. For a 30% commission, we will add to the patient's account 43% of the amount of our treatment-related charges and accrued interest so that we can recover our charges and interest after the collection agency deducts its 30% commission. If an account is collected after the start of a collection lawsuit, we will add reasonable attorneys' fees and expenses and court costs to our treatment-related charges and interest, in addition to the collection agency's commission.

Consent to disclosures
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 or a 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):_____

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Authorization for Caregiver to Act for Parent or Guardian

Child's name: _____ Date of birth: _____

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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: _____