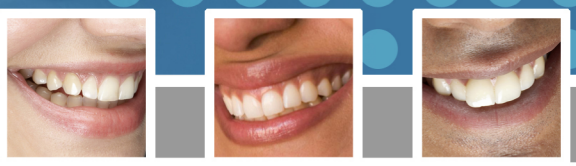
Ryan T. Beelman D.M.D
308 Harwood Rd
Bedford, TX 76021

(817)282-1241
info@beelmandental.com
www.beelmandental.com



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name:* _____ (Last) * _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:* _____ Prev. Visit: _____ Email Address: _____

Phone:* _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address:* _____ _____

* _____ (City) * _____ (State) * _____ (Zip Code)

Preferred appointment times:

* ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

Whom may we thank for referring you to our practice?

* ☐ Dental Office ☐ Google ☐ Facebook ☐ Postcard ☐ Family/Friend

Name of person, office, or other source referring you to our practice:

* _____

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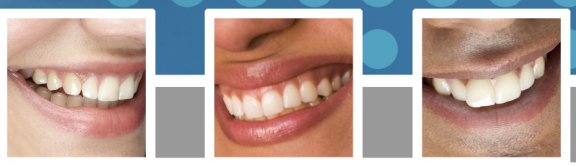

Spouse or Responsible Party Information

The following is for: * ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: * Last * First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: * ◯ Male ◯ Female Family Status: * ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: * Email Address:

Phone: * Home Work Ext Mobile Best time to call:

Address: *
* City * State * Zip Code

Employment Information

The following is for: * ☐ the patient ☐ the person responsible for payment

Employer Name: * Phone:

Address:
City State Zip Code

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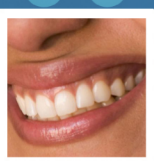
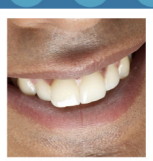

Primary Insurance Information

Primary Dental Insurance:

Name of Insured:* _____ * _____ _____
Last First MI

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

Insured's Address: _____ _____

_____ _____ _____
City State Zip Code

Insured's Employer Name:* _____

Employer Address: _____ _____

_____ _____ _____
City State Zip Code

Patient's relationship to insured:* ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:* _____

Insurance Address: _____ _____

_____ _____ _____
City State Zip Code

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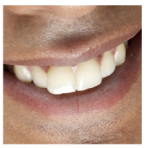

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured:* _____ * _____ _____
Last First MI

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

Insured's Address: _____ _____

_____ _____ _____
City State Zip Code

Insured's Employer Name:* _____

Employer Address: _____ _____

_____ _____ _____
City State Zip Code

Patient's relationship to insured:* ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:* _____

Insurance Address: _____ _____

_____ _____ _____
City State Zip Code

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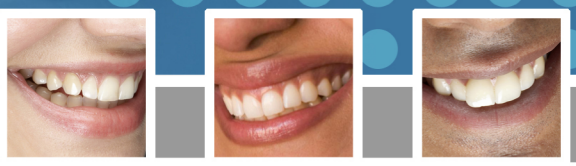

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any 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.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: *

Relationship to Patient:

*

Response Date:

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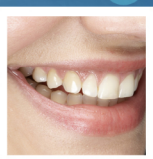

Medical History

Physician Name:

Phone:

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Allergies-Seasonal
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hayfever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Allergy- Tetanus
- [ ] Allergy-Lactose
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Ht.Valves
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Cancer
- [ ] Cardio Disease
- [ ] Diabetes type 1 or 2
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Excessive Urination
- [ ] Fainting
- [ ] GERD
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Joint replacement
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Migraines
- [ ] Mouth ulcers
- [ ] Multiple Sclerosis
- [ ] Nervous Disorders
- [ ] NeurologicalDisorder
- [ ] Osteoporosis
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Sleep Disorder
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Do you have any allergies?

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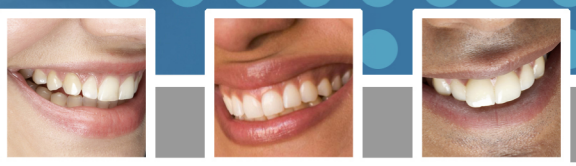

List your current medications

*

Have you had a serious illness, operation or been hospitalized in the past 5 years?

◯ Yes ◯ No

If yes, what was the illness or problem?

Joint Replacement: have you had an orthopedic total joint (hip,knee,elbow,finger) replacement?

* ◯ Yes ◯ No

If so when

*

Do you take or are scheduled to receive an antiresorptive agent (Ex: Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

* ◯ Yes ◯ No

Do you use tobacco products?

◯ Yes ◯ No

Do you drink alcohol?

◯ Yes ◯ No

Women Only:

Are you pregnant?

* ◯ Yes ◯ No

Number of weeks?

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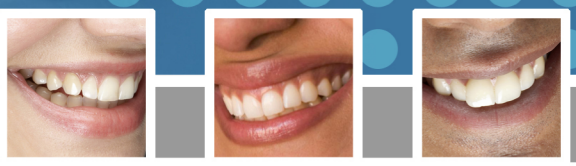

Taking Birth control pills or Hormonal replacement?

* ◯ Yes ◯ No

Dental Information

What is the reason for our dental visit today?

Have you had any of the following?

- ☐ Periodontal (gum) treatments
- ☐ Dental pain or discomfort
- ☐ Neck Pains
- ☐ Mouth sores or ulcers
- ☐ Orthodontic (braces) treatments
- ☐ Earaches
- ☐ Jaw issues (clicking, popping or discomfort)
- ☐ Grinding your teeth

Do you wear dentures or partials?

◯ Yes ◯ No

How do you feel about your smile?

Patient/Legal Guardian

Signature: _____ Date: _____

Dentist

Signature: _____ Date: _____

Response Date: _____

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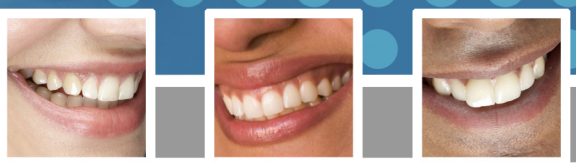

Consent for Internet Communications

Patient Name:* _____ * _____ _____ _____
Last First MI Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

* ☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature of patient, parent, or guardian:

Signature: _____ Date:* _____

Relationship to Patient:

* _____

Response Date: _____

BEELMAN DENTAL
RYAN T. BEELMAN, DMD

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Privacy Officer: _____ Contact number: _____

External HIPAA Privacy and Security Resource contact: David Wornica, CHPSE. Contact number: 469-342-8300 ext. 628.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by Federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR IMPLIED CONSENT

BEELMAN DENTAL
RYAN T. BEELMAN, DMD

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

Treatment: We may use and disclose your protected health information (PHI) to provide, coordinate, or manage your healthcare and related services. This includes sharing your information with other healthcare providers, such as specialists or laboratories, who assist in your treatment at the request of your dentist.

Our office may also use HIPAA-compliant artificial intelligence (AI) tools to support your care. These tools help review dental images (such as X-rays) and other health data to assist with diagnosis and treatment planning. AI is used to enhance, not replace, your provider's clinical judgment. All AI-assisted findings are reviewed and approved by a licensed dentist before being used in your treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services, This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities, For example, obtaining approval for procedures may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this office, These activities may include, but are not limited to, quality assessment activities, employee review activities and staff training.

For example, we may disclose your protected health information to interns or precepts that see patients at our office, In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses, We may also call you by name in the reception area when your doctor is ready to see you, We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "Business Associates" that perform various activities (e,g,, billing, transcription services for the practice), Whenever an arrangement between our office and a Business Associate involves the use or disclosure of your protected health information, we will have a written agreement with that Business Associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you, We may also use and disclose your protected health information for other internal marketing activities, For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you, You may request that these materials not be sent to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT MAY BE MADE WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

For example, with your written, signed authorization, we may use your demographic information and the dates that you received treatment from our office, as necessary, in order to contact you for fundraising activities supported by our office.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT

BEELMAN DENTAL
RYAN T. BEELMAN, DMD

YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT
We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable Federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of

criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Workers' Compensation: We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Special Protections for Substance Use Disorder Records: If we receive or maintain records related to substance use disorder treatment that are protected under federal law (42 CFR Part 2), those records are subject to additional confidentiality protections.

- These records may be used and disclosed for treatment, payment, and health care operations as permitted by law.
- We will not use or disclose these records, or testimony about their contents, in civil, criminal, administrative, or legislative proceedings against you unless permitted by law, with your written consent, or pursuant to a court order that meets applicable legal requirements.
- Other uses and disclosures of substance use disorder records require your written authorization or must otherwise be permitted or required by law.

Special Protections for Reproductive Health Information: Information related to reproductive health care may be subject to additional privacy protections under federal law and our internal privacy practices.

- We may use and disclose reproductive health information for treatment, payment, and health care operations as permitted by law.
- We will not use or disclose reproductive health information for the purpose of investigating or imposing liability on an individual for seeking, obtaining, providing, or facilitating lawful reproductive health care.
- Other uses and disclosures of reproductive health information require your written authorization or must otherwise be permitted or required by law.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record

set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please ask your doctor if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to a staff member in our office. The staff member will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff member provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

You may have the right to have your doctor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please ask your doctor if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limits.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, to the Texas Attorney General's Office, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer in writing at our office address. Our website may offer additional information about the complaint process.

This notice was published and becomes effective on February 16, 2026.