The Doctors BERGER FAMILY DENTISTRY

NEW PATIENT INFORMATION

Today's Date: _____

First Name _____ Last Name _____ Date of Birth _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Address _____

Social Security Number: _____-____-_____ E-Mail Address _____

How did you hear about our office? _____

INSURANCE INFORMATION

Insurance Company Name _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber Social Security Number: _____-____-_____ ID # _____

Employer _____

Patient Name	MEDICAL HISTORY
Patient Account No.	Medical Alert

Welcome! *So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-Rays** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State_____ Zip _____

Telephone _____

How often do you have dental examinations?_____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (interplak, toothpick, etc.) _____

Do you have any dental problems now? ○Yes ○No

If yes, please describe: _____

_____

Are any of your teeth sensitive to:

Hot or cold? ○ **Yes** ○ **No**

Sweets? ○ **Yes** ○ **No**

Biting or Chewing? ○ **Yes** ○ **No**

Have you noticed any mouth odors or bad tastes? ○ **Yes** ○ **No**

Do you frequently get cold sores, blisters or any other oral lesions? ○ **Yes** ○ **No**

Do your gums bleed or hurt? ○ **Yes** ○ **No**

Have your parents experienced gum disease or tooth loss? ○ **Yes** ○ **No**

Have you noticed any loose teeth or change in your bite? ○ **Yes** ○ **No**

Does food tend to become caught between your teeth? ○ **Yes** ○ **No**

If yes, where?

_____

Do you:

Clench or grind your teeth while awake or asleep? ○ **Yes** ○ **No**

Bite your lips or cheeks regularly? ○ **Yes** ○ **No**

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) ○ **Yes** ○ **No**

Mouth breathe while awake or asleep? ○ **Yes** ○ **No**

Have tired jaws, especially in the morning? ○ **Yes** ○ **No**

Smoke/chew tabacco? ○ **Yes** ○ **No**

Is there anything else about having dental treatment that you would like us to know? If yes, please describe ○ **Yes** ○ **No**

_____

_____

_____

_____

Have you ever had:

Orthodontic treatment? ○ **Yes** ○ **No**

Oral Surgery? ○ **Yes** ○ **No**

Periodontal treatment? ○ **Yes** ○ **No**

Your teeth ground or the bite adjusted? ○ **Yes** ○ **No**

A bite plate or mouth guard? ○ **Yes** ○ **No**

A serious injury to the mouth or head? ○ **Yes** ○ **No**

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw? ○ **Yes** ○ **No**

Pain? (joint, ear, side of face)

Difficulty in opening or closing the mouth? ○ **Yes** ○ **No**

Difficulty in chewing on either side of the mouth? ○ **Yes** ○ **No**

Headaches, neckaches, or shoulder aches? ○ **Yes** ○ **No**

Sore muscles (neck, shoulders)? ○ **Yes** ○ **No**

Are you statisfied with your teeth's appearance? ○ **Yes** ○ **No**

Would you like to keep all of your teeth all of your life? ○ **Yes** ○ **No**

Do you feel nervious about having dental treatment? ○ **Yes** ○ **No**

If so, what is your biggest concern? ○ **Yes** ○ **No**

_____

Have you ever had an upsetting dental experience? ○ **Yes** ○ **No**

If yes, please describe

_____

_____

_____

Patient Name	DENTAL HISTORY
Patient Account No.	Medical Alert

Have you been under the care of a medical doctor during the past two years?..... ○ Yes ○ No
If yes, for what?_____
Physician's Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Have you taken any medication or drugs during the past two years?..... ○ Yes ○ No
Are you taking any medication, drugs or pills now?..... ○ Yes ○ No
If yes, please list name and dosage _____
Are you aware of having an allergic **(or adverse reaction)** to any medication or substance?..... ○ Yes ○ No
If yes, please list: _____
Have you been a patient in the hospital during the past five years?..... ○ Yes ○ No

Indicate which of the following you have had, or have at present. Select "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)..... ○ Yes ○ No
Chest Pain..... ○ Yes ○ No
Congenital Heart Disease..... ○ Yes ○ No
Heart Murmur..... ○ Yes ○ No
High Blood Pressure..... ○ Yes ○ No
Mitral Valve Prolapse..... ○ Yes ○ No
Artificial Heart Valve..... ○ Yes ○ No
Heart Pacemaker..... ○ Yes ○ No
Rheumatic Fever..... ○ Yes ○ No
Arthritis/Rheumatism..... ○ Yes ○ No
Cortisone Medicine..... ○ Yes ○ No
Swollen Ankles..... ○ Yes ○ No
Stroke..... ○ Yes ○ No
Diet (Special/Restricted)..... ○ Yes ○ No
Artificial Joints (hip, knee, etc.)..... ○ Yes ○ No
Kidney Trouble..... ○ Yes ○ No

Ulcers..... ○ Yes ○ No
Diabetes..... ○ Yes ○ No
Thyroid Problems..... ○ Yes ○ No
Glaucoma..... ○ Yes ○ No
Contact lenses..... ○ Yes ○ No
Emphysema..... ○ Yes ○ No
Chronic Cough..... ○ Yes ○ No
Tuberculosis..... ○ Yes ○ No
Asthma..... ○ Yes ○ No
Hay Fever..... ○ Yes ○ No
Latex Sensitivity..... ○ Yes ○ No
Allergies or Hives..... ○ Yes ○ No
Sinus Trouble..... ○ Yes ○ No
Radiation Therapy..... ○ Yes ○ No
Chemotherapy..... ○ Yes ○ No
Tumors..... ○ Yes ○ No

Hepatitis A (infectious) B (serum).... ○ Yes ○ No
Venereal Disease..... ○ Yes ○ No
A.I.D.S. ..... ○ Yes ○ No
H.I.V. Positive..... ○ Yes ○ No
Cold Sores/Fever Blisters..... ○ Yes ○ No
Blood Transfusion..... ○ Yes ○ No
Hemophilia..... ○ Yes ○ No
Sickle Cell Disease..... ○ Yes ○ No
Bruise Easily..... ○ Yes ○ No
Liver Disease..... ○ Yes ○ No
Yellow Jaundice..... ○ Yes ○ No
Neurological Disorders..... ○ Yes ○ No
Epilepsy or Seizures..... ○ Yes ○ No
Fainting or Dizzy Spells..... ○ Yes ○ No
Nervous/Anxious..... ○ Yes ○ No
Psychiatric/Psychological Care..... ○ Yes ○ No

Do you use more than two pillows to sleep?..... ○ Yes ○ No
Have you lose or gained more than 10 pounds in the past year?..... ○ Yes ○ No
Do you have or have you had any disease, condition, or problem not listed?..... ○ Yes ○ No
If yes, please list: _____
Women. Are you: **Pregnant?** ○ Yes ○ No If yes, how many months?___ **Nursing?** ○ Yes ○ No **Taking birth control pills?** ○ Yes ○ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

☐ **By checking this box, I authorize the electronic signature.** Date_____

History Review

Dentist Signature _____ Date_____

PATIENT PRIVACY CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we will provide the minimum amount of necessary information to only those whom we feel are in need of your health care information regarding treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may at times have indirect treatment relationships regarding you as a patient, such as laboratories that only interact with doctors and not the patient directly. At those times we may have to disclose personal health information for the purpose treatment, payment and/or health care operations. These entities are most often not required to obtain direct patient consent.

You may refuse to consent to the use or disclosure of your personal health information in writing. Therefore, under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). At anytime in the future you may request in writing to refuse all or part of this document that you are signing today. You may not revoke previous actions taken, which have relied on this, or an earlier signed consent.

If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions or revoke consent in writing after you have reviewed our privacy notice.

☐ **By checking this box, I authorize the electronic signature. Date**_____

Print Name _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued patients:

The misuse of Personal Health Information (PHI) has been indentified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "privacy rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

If your record is requested to leave or be transferred from our office, your signature is required below to release this record and all the information pertaining to your treatment to the person or persons requesting such documents.

☐ **By checking this box, I authorize the electronic signature. Date**_____

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

IT IS THE UNDERSTANDING, AGREEMENT AND CERTIFICATION OF THE UNDERSIGNED THAT:

The undersigned shall be financially responsible for and agrees to pay for all services rendered to the patient, at the rate established in accordance with usual charges for such services, and the obligation of the undersigned is an original, direct, independent and positive promise to pay, based on the credit of the undersigned, and is not a collateral or contingent promise to answer for the debt of another.

If the patient fails to make payment for all charges when due and this account is reffered to an attorney for collection, then the patient promises to agree to pay all collection costs including attorney fees of 33 1/3% of the principle amount due and owing when turned over for collection. Finance charge of 1.91% per month which is an ANNUAL PERCENTAGE RATE OF 22.92% to be applied to unpaid balance of account at the end of each billing cycle.

In the event this matter is turned over for collection, I hereby expressly give my permission for my current employer(s) to provide verification of my said employment to this office, or the attorney, Tiffany & Tiffany P.L.L.C.

The undersigned has read and fully understands the meaning and consequences of the foregoing and that no guarantee or assurance of result has been made.

Our mission is to deliver the finest comprehensive treatment available today and we want it performed to your satisfaction. Payment is due at the time of treatment. If this is not convenient for you, we have monthly payment through Care Credit, which allows you to start your treatment today. Your payment options are: Check, Cash, MasterCard/Visa, Discover or Care Credit.

A $100.00/doctor &/or $50.00/hygienist per hour fee will be assessed to your account in the event an appointment is not cancelled within 48 hours.

I have read the above form and fully agree to and understand the conditions set forth regardless of insurance coverage, court litigation, or other party involvement.

Responsible Party _____ **Date** _____

I authorize release of any information relating to my treatment. I understand that I am responsible for all costs and dental treatment. I hereby authorize payment directly to THE DOCTORS BERGER, D.M.D. of the group insurance benefits, otherwise payable to me.

☐ **By checking this box, I authorize the electronic signature of the insured.**