

Welcome!

Thank you for selecting our healthcare team! We strive to provide our patient with the best possible dental care. To help us meet all your dental needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

Date _____ DL # _____
SSN _____

Patient Information (Confidential)

Name _____ Preferred _____ Male or Female
Birthdate _____ Home Phone _____ Work Phone _____ Cell Phone _____
Address _____ Apt# _____ City/State/Zip _____
Married _____ Single _____ Child _____ Other _____ Is Patient a Student? Yes _____ No _____
Patient's or Parent's Employer _____
E-Mail Address _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone: _____

Responsible Party (If different from patient)

Name of Person Responsible for this Account _____ Relationship _____
to Patient _____
Address _____ Apt # _____ City/State/Zip _____
Birthdate _____ Social Security Number _____ Home Phone _____
Employer _____ Work Phone _____ Cell Phone _____
Is this person currently a patient in our office? Yes _____ No _____

Insurance Information

Name of Insured _____ Relationship _____
to Patient _____
Birthdate _____ Social Security Number _____ Home Phone _____
Employer _____ Work Phone _____
Insurance Company _____ Group Number _____
Insurance Co. Address _____ City/State/Zip _____
DO YOU HAVE ADDITIONAL INSURANCE? YES _____ NO _____ Relationship _____
Name of Insured _____ to Patient _____
Birthdate _____ Social Security # _____
Employer _____ Work Phone _____
Insurance Company _____ Group Number _____
Insurance Co. Address _____ City/State/Zip _____

Patient Medical History Name: _____ Date: _____

Physician _____ Office Phone _____

Yes No

- 1. Are you currently under medical treatment?
- 2. Within the last 5 years, have you ever been hospitalized for any surgical operation or serious illness? If so, please explain _____
- 3. Are you taking any medication(s) including non-prescription medicine?
- 4. Do you have a cardiac pacemaker?
- 5. Do you use tobacco products?
- 6. Do you use controlled substances?
- 7. Do you take blood thinners (i.e. COUMADIN, PLAVIX)?
- 8. Do you take medications? If so, please list _____

9. Please circle if you are allergic to or have had any reactions to the following:

Any metals (e.g. nickel, mercury, etc) Aspirin Barbiturates
Codeine Latex rubber Local anesthetics (e.g. novocaine)
Penicillin Sedatives Sulfa Drugs
Other _____

10. Women only:

	Yes	No
Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>

11. When was your last dental visit? _____

What was the reason for that visit? _____

12. Do you have or have you had any of the following?

	Yes	No		Yes	No
HIV Disease	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Angina	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Spleen Removal	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Infection	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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.

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. 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. The fee for a returned check is \$30.00

A service charge of 1 ½% 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 should this account be turned over to a collection agency for delinquency, that a collection and/or attorney's fee of 35% and all related collection cost will be added to my outstanding balance and payable to the collection agency by me.

I understand that the fee estimate listed 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, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall 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 at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their consent.

_____ Date:_____ Relationship to Patient:_____
Signature of patient, parent or guardian

_____ Date:_____ Relationship to Patient:_____
Signature of guarantor or payment/responsible party

*FINANCIAL POLICY OF
BERGER DENTAL GROUP, P.A.*

Payment is due when services are rendered.

Payment may be made by cash, check, debit card, or credit card (Visa, Master Card, American Express, and Discover). Payment for procedures not specifically covered or fully covered by an insurance carrier are due at the completion of each visit this includes deductibles and co-payments.

METHODS OF PAYMENT

PAYMENT IN FULL:

Cash, check, debit card, or credit card is accepted for full payment the day of or prior to treatment. The insurance payment sent by your insurance company will go directly to the patient (guarantor).

EASY PAY:

Assignment of insurance payment is made to Berger Dental Group, P.A. The patient pays the estimated difference at the time the service is provided. A signed document is executed granting the practice the right to place the remaining balance on a bankcard following insurance payment. Printed below is the consent form for the "EASY PAY" method.

ESTIMATE-PLUS PAYMENT PLAN:

Payment of the estimated Patient Portion, to cover any insurance shortfall in coverage, is to be paid at the time of treatment. The practice will then accept the insurance's payment and then bill any remaining balance if necessary, or refund any overpayment to the patient.

I have read this document and understand that this is an explanation of Berger Dental Group, P.A. financial and insurance policies and I agree to comply.

I assign my insurance benefits to the provider listed above. I understand this form is valid for one year unless I cancel the authorization through a written notice.

SIGNATURE _____ DATE _____

EASY PAY CONSENT (RECOMMENDED)

PATIENT NAME: _____

CARDHOLDER NAME/NUMBER: _____

CITY: _____ STATE: _____ ZIP: _____

I authorize Berger Dental Group, P.A. the right to keep my signature on file and to charge any current charges to my Visa, Master Card, American Express or Discover Card.

Authorized Signature _____

X-RAYS (REQUIRED)

I understand it will be my responsibility to pay for any and all x-rays that my insurance company does not cover for whatever reason.

Signature

Date

Patient Medical History

Do you have or have you ever had a history of the following conditions:

	Yes	No
Multiple Myeloma	<input type="checkbox"/>	<input type="checkbox"/>
Metastatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Paget's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Osteomalacia	<input type="checkbox"/>	<input type="checkbox"/>
Osteonecrosis of the jaws	<input type="checkbox"/>	<input type="checkbox"/>

Do you take or have you ever taken any of the following medications or any other Bisphosphonate medication?

	Yes	No
Zometa	<input type="checkbox"/>	<input type="checkbox"/>
Aredia	<input type="checkbox"/>	<input type="checkbox"/>
Fosamax	<input type="checkbox"/>	<input type="checkbox"/>
Boniva	<input type="checkbox"/>	<input type="checkbox"/>
Actonel	<input type="checkbox"/>	<input type="checkbox"/>
Didronel	<input type="checkbox"/>	<input type="checkbox"/>
Skelid	<input type="checkbox"/>	<input type="checkbox"/>