BERKSHIRE DENTAL

FAMILY • COSMETIC • IMPLANT

PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

Preferred Name (if different)? _____ Gender: Male Female

Birthday (MM/DD/YY):_____ Social Security No: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Primary Phone: _____ Is this a cell phone? Yes No

Cell Phone (if not above): _____ Text OK? Yes No

E-mail*: _____

Single Married Other

How did you hear about our office? _____

Name of Employer/School (if student): _____

Name of Person Responsible for Account: _____

Address (if different): _____

Phone (if different): _____

Name of Spouse: _____

Emergency Contact Person: _____

Phone: _____

Relationship: _____

Previous / Present Dentist: _____

DENTAL INSURANCE INFORMATION

First Dental Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Employer: _____

Social Security #: _____ Birthdate: _____

Subscriber ID: _____ Insurance Phone No: _____

Group #: _____ Policy #: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Second Dental Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Employer: _____

Social Security #: _____ Birthdate: _____

Subscriber ID: _____ Insurance Phone No: _____

Group #: _____ Policy #: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

(CONTINUES ON NEXT PAGE)

MEDICAL HISTORY

Primary Care Physician: _____ **Phone:** _____

Are you currently under the care of a specialty physician? ☐ **YES** ☐ **NO If yes, explain:** _____

Do you currently have, or have you ever had, any of the following:

AIDS	YES	NO	Glaucoma	YES	NO	Multiple Sclerosis	YES	NO
Anemia	YES	NO	Heart Defects	YES	NO	Nervousness/Depression	YES	NO
Artificial Heart Valve	YES	NO	Heart Disease/Attack	YES	NO	Osteoporosis	YES	NO
Artificial Joints/Prosthesis	YES	NO	Heart Failure	YES	NO	Pain in Jaw Joints	YES	NO
Arthritis	YES	NO	Heart Murmur	YES	NO	Psychiatric Treatment	YES	NO
Asthma	YES	NO	Heart Pacemaker	YES	NO	Rheumatic Fever	YES	NO
Bruise Easily	YES	NO	Heart Surgery	YES	NO	Scarlet Fever	YES	NO
Cancer/Leukemia	YES	NO	Hemophilia	YES	NO	Sickle Cell Disease	YES	NO
Chemotherapy	YES	NO	Hepatitis	YES	NO	Severe Allergies/hives	YES	NO
Chest Pain	YES	NO	High Blood pressure	YES	NO	Sinus Trouble	YES	NO
Diabetes	YES	NO	HIV Positive	YES	NO	Stroke	YES	NO
Difficulties Breathing	YES	NO	Kidney Disease	YES	NO	Thyroid Disease	YES	NO
Drug Addiction	YES	NO	Liver Disease	YES	NO	Yellow Jaundice	YES	NO
Emphysema	YES	NO	Loss of Appetite	YES	NO	Use a C-Pap	YES	NO
Epilepsy or Seizures	YES	NO	Loss of Sleep	YES	NO	Mitral Valve Prolapse	YES	NO
Fainting/Dizzy Spells	YES	NO	Loud Snoring	YES	NO	**Adverse Reaction to local anesthetic**		
(Frequent) Cold Sores	YES	NO				**(Lidocaine)**	YES	NO

Other Pre-existing conditions: _____

Are you **pregnant**? YES NO

Do you have a **LATEX** allergy? YES NO

Are you taking, or have you ever taken, **bisphosphonates**? YES NO

Are you currently taking **blood thinners**? YES NO

Do you smoke? YES NO If **yes**, how long?_____ How much?_____

List any, and all, medications that you are currently taking: _____

List any and all medications that you are knowingly **ALLERGIC** to, or have had an adverse reaction to:

DENTAL HISTORY

Has the fear of discomfort kept you from regular dental visits?	YES	NO	Are you self-conscious about your teeth?	YES	NO
			Do your jaws often feel tired or sore?	YES	NO
Are you satisfied with your past dentistry?	YES	NO	Do you experience excessive headaches and/or neck pain?		
Have you ever had a bad dental experience?	YES	NO		YES	NO
Do your gums bleed easily?	YES	NO	Do you experience TMJ issues?	YES	NO
Are your teeth sensitive to hot, cold, sweets?	YES	NO	Are you aware of clenching or grinding?	YES	NO
Do you get food stuck or caught between teeth?	YES	NO	Have you ever had braces?	YES	NO

What prompted you to seek dental care at this time?_____

Approximately how long has it been since your last dental exam/cleaning?_____

What, if anything, would you do to change the appearance of your teeth: ***(circle all that apply)***

WHITER/STRAIGHTER LONGER/SHORTER SHAPED DIFFERENTLY NOTHING

CONSENT

I acknowledge that all the above information is accurate to the best of my knowledge. I authorize this office and its trained staff to take x-rays & other diagnostic aids needed to make proper diagnosis of my dental needs. I authorize this office and its trained staff to perform all forms of treatment, as is indicated. I understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I give my permission to release medical/dental information as needed to receive proper treatment from other health providers.

X _____ _____ **X** _____

Signature of Patient/Parent or Guardian **Staff Signature** **Date**

FINANCIAL AGREEMENT

By signing below, you acknowledge and understand that payment in full for all services is required at time of visit, unless prior arrangements have been made.

INSURANCE FILING

By signing below, you acknowledge and understand that you (patient) are ultimately responsible for payment in full on your account, not the insurance company. We do file dental insurance claims as a courtesy to our patients. You understand that we can only make ***ESTIMATES*** regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, you understand that the remaining balance is due and payable immediately by you.

ASSIGNMENT OF INSURANCE BENEFITS

By signing below, you hereby assign all insurance benefits directly to our office which are otherwise payable to you. You also hereby authorize the release of any information relating to any claims. You understand that you are financially responsible for charges not paid by this assignment.

X _____

Responsible Party Signature

DELINQUENT ACCOUNTS

By signing below, you acknowledge and understand that all delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION PROCEEDINGS

By signing below, you acknowledge and understand that in the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any and all reasonable collection costs and/or attorney fees, in addition to the balance owed. All accounts turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed, and you will be responsible for payment of regular fee for procedures at the time of service.

X _____

Responsible Party Signature

USE OF PHOTOGRAPHS, VIDEOS, AND IMAGES

By signing below, you acknowledge and understand that photographs, videos, and other images, such as x-rays, and other records may be created during my examination, treatment, and follow-up care.

X _____

Responsible Party Signature

NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge and understand that you have received and read a copy of the Notice of Privacy Practices.

X _____

Responsible Party Signature

BERKSHIRE DENTAL

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect November 1, 2015 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorizations: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information of to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS Access: you have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of health information by alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **You must make your request in writing.** Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. **Your request must be in writing, and it must explain why the information should be amended.** We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS OR CONCERNS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACT US

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