BERTHELOT DENTAL
General Dentistry

Dr. Mr. Mrs. Ms. Miss

First: _____ Middle: _____ Last: _____ I II III Jr. Sr.

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Date of Birth: ____/____/_____ Sex: **M F** Marital: **Single Married Divorced Widowed**

Patient Social Security Number: _____ Student: **No FT PT**

Responsible Party: _____ Phone: _____ Relation: _____

Responsible Party's Address: _____

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear about Berthelot Dental? _____

Do you have Dental Insurance? **Yes No**

Primary Insured

Insured Party: _____ Relationship to Insured Party: **Self Spouse Child Other**

Insured Party's DOB: _____ Insured Party's SSN: _____

Employer Name: _____ Employer Phone: _____

Insurance Company: _____ Insurance Group #: _____

Insurance Phone #: _____ Insurance Fax: _____

Do you have *secondary* Dental Insurance? **Yes No**

Secondary Insured

Insured Party: _____ Relationship to Insured Party: **Self Spouse Child Other**

Insured Party's DOB: _____ Insured Party's SSN: _____

Employer Name: _____ Employer Phone: _____

Insurance Company: _____ Insurance Group #: _____

Insurance Phone #: _____ Insurance Fax: _____

*** Please present PHOTO ID & INSURANCE CARD(S) to receptionist to be scanned into your chart. ***

Health Information

Patient's Name: _____ Date of Last Medical Exam: _____

Physician's Name: _____ Phone #: _____

Are you currently under medical treatment? **Yes** **No** If yes, please explain_____

_____

Have you been hospitalized for any surgery or serious illness in the last 5 years? **Yes** **No**

If yes, please explain _____

List all medications you are currently taking: _____

_____

Do you have or have you had any of the following? Please circle Y or N.

Anemia/Hemophilia	**Y**	**N**	Kidney Disease	**Y**	**N**
Arthritis	**Y**	**N**	Kidney Failure	**Y**	**N**
Asthma	**Y**	**N**	Leukemia	**Y**	**N**
Cancer	**Y**	**N**	Liver Disease	**Y**	**N**
Cardiac Pacemaker	**Y**	**N**	Low Blood Pressure	**Y**	**N**
Chemical Dependency	**Y**	**N**	Mitral Valve Prolapse	**Y**	**N**
Chest Pains/Angina	**Y**	**N**	Osteoporosis	**Y**	**N**
Congenital Heart Disease	**Y**	**N**	Pneumonia	**Y**	**N**
Diabetes: Type **I** or **II**	**Y**	**N**	Psychiatric Disorder	**Y**	**N**
Easily Winded	**Y**	**N**	Radiation Therapy	**Y**	**N**
Emphysema	**Y**	**N**	Recent Weight Loss	**Y**	**N**
Epilepsy/Seizures/Date_____	**Y**	**N**	Recurrent Bronchitis	**Y**	**N**
Frequently Tired	**Y**	**N**	Respiratory Problems	**Y**	**N**
Glaucoma	**Y**	**N**	Rheumatic Fever	**Y**	**N**
Hay Fever/ Allergies	**Y**	**N**	Skin Disorders	**Y**	**N**
Heart Attack/Date_____	**Y**	**N**	Stomach/Intestinal Disease	**Y**	**N**
Heart Murmur	**Y**	**N**	Stroke/Date_____	**Y**	**N**
Heart surgery/Date_____	**Y**	**N**	Swollen Ankles	**Y**	**N**
Hepatitis: Type **A** **B** **C**	**Y**	**N**	Thyroid Problem: **Hi** or **Low**	**Y**	**N**
High Blood Pressure	**Y**	**N**	Tuberculosis	**Y**	**N**
HIV / AIDS	**Y**	**N**	Venereal Disease	**Y**	**N**
Joint Replacement/Date _____	**Y**	**N**	Other_____	**Y**	**N**

Are you **ALLERGIC** to or have you had **ANY** reaction to the following?

Aspirin	**Y**	**N**	Local Anesthetics	**Y**	**N**
Barbituates	**Y**	**N**	Metals (Nickel, Mercury, etc.)	**Y**	**N**
Codeine	**Y**	**N**	Sedatives	**Y**	**N**
Iodine	**Y**	**N**	Sulfa Drugs	**Y**	**N**

Other _____

Any Antibiotics (If yes, which antibiotics?) _____

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing **BISPHOSPHONATES**? **Y** **N**

Do you use tobacco? **Y (smoke/smokeless)** **N** Do you use alcoholic beverages? **Y** **N**

Do you wear contact lens? **Y** **N** Do you use controlled substances? **Y** **N**

LADIES ONLY: Are you taking oral contraceptives? **Y** **N** Are you nursing? **Y** **N**

Are you pregnant or think you may be pregnant? **Y** **N** If so, what month? _____

Dental Information

What is the reason for your visit today? _____

How often do you visit the dentist? _____

Date of last dental visit? _____Date of last dental X-rays:_____

If you are wearing partial(s) or denture(s), what is the age of the partial(s) / denture(s): _____

I brush _____ times a day. I floss _____ times a day.

Do your gums bleed while brushing or flossing?	**Y**	**N**
Are your teeth sensitive to HOT/COLD liquids/foods?	**Y**	**N**
Are your teeth sensitive to SWEET/SOUR liquids/foods?	**Y**	**N**
Do you feel pain to any of your teeth?	**Y**	**N**
Do you have any sores or lumps in or near your mouth?	**Y**	**N**
Have you ever had any head, neck or jaw injury?	**Y**	**N**
Have you ever experienced any of the following problems in your jaw?	**Y**	**N**
Clicking?	**Y**	**N**
Pain?	**Y**	**N**
Difficulty opening or closing?	**Y**	**N**
Difficulty chewing?	**Y**	**N**
Do you have frequent headaches?	**Y**	**N**
Do you clench or grind your teeth?	**Y**	**N**
Do you bite your lips or cheeks frequently?	**Y**	**N**
Have you ever had any difficult extractions in the past?	**Y**	**N**
Have you ever had any prolonged bleeding following extractions?	**Y**	**N**
Have you had any orthodontic treatment?	**Y**	**N**
Do you like your smile?	**Y**	**N**

New Patient Consent Form

Consent for Dental Exam, X-Rays, and Treatment Planning and Acknowledgement of Receipt of Information

What you are being asked to sign is confirmation that you understand the nature and purpose of your visit and the risks associated. Ask about anything you do not understand. We will be pleased to explain.

I hereby authorize and direct **Berthelot Dental** Doctors, assistants, hygienists, and specialists of their choice to perform upon _____ the following dental procedures:

(patient's name)

DENTAL EXAM
DIAGNOSTIC X-RAYS
TREATMENT PLAN

Risk associated with the above procedures:

I understand that dentistry is not an exact science and that complications may occur despite our best efforts. A partial listing of the risk known to be associated with these procedures:

- Pain
- Allergic reaction to latex products
- Stretching of the mouth which may cause bruising or result in cracking of the lips.

Acknowledgement

I acknowledge that I have read and I understand the information contained in this consent form (or that it has been read to me).

I hereby authorize **Berthelot Dental** Doctors, hygienists, assistants, or specialists of their choice to perform the dental exam, x-ray, and treatment planning. This Consent Form will remain valid until revoked by me in writing. All blanks were filled in prior to my signature. I waive further disclosures or information.

Patient's Signature _____ Date _____

Authorization for Dental Care on a Minor

I authorize dental treatment to be rendered on my child / minor, _____, with my physical presence in the dental office only. **I have been advised that it is REQUIRED to have a parent or legal guardian present in the office during treatment in case of any complications or medical situations that may arise.** With knowledge of this, I authorize the Berthelot Dental team to take any emergency care/action or precautions deemed necessary. I still retain the authority to approve or decline treatment to be rendered and will make that designation clear before the appointment either in person or by phone consent.

Parent/ Guardian's Signature _____ Date _____

Relationship to patient _____

Financial Policy

In order to be impartial to everyone, **payment is due when services are rendered**. We ask that you read and sign this statement prior to service. Your co-pay and deductible are due in full at time of the service. Master Card, Visa, Discover, American Express, personal checks, or cash may be used for any payment. Insurance assignment for treatment is also accepted with preauthorization.

ACKNOWLEDGEMENT

I hereby certify that the medical and dental history provided is correct to the best of my knowledge and give my consent for the doctors and staff at Berthelot Dental to treat my dental needs based on this information.

MISSED APPOINTMENTS

In order that we do not keep you waiting, we reserve your appointment time for only you and we do not double-book appointments. This allows us to see you on time and avoid wasting your time. Forty-eight (48) hours' notice is required if you need to change an appointment. **You may be charged a cancellation fee or DISMISSED as a patient from our office following multiple failed appointments.**

REGARDING INSURANCE

We will be happy to assist you in filing your insurance claim, although **you are ultimately responsible for your bill.** Our main objective is to help you keep your teeth for a lifetime. We provide the most expert treatment available at fees which reflect our level of care and expertise. As a courtesy to you, we will assist you in filing your insurance benefits. To avoid any confusion, please be aware of the following facts:

1. No insurance company will pay for all of every procedure. You may be fortunate enough to receive some financial assistance from your insurance company.
2. Each insurance company will pay different amounts depending upon the policy you or your employer chose to purchase.
3. Your insurance company may try to confuse you by claiming fees or procedures are not "customary". This is their method of saying they will not pay beyond arbitrary limits set in your policy. For instance, your insurance policy may state that it covers 80% of an arbitrary amount set by your insurance company so that they continue to make a profit.
4. Our office will be happy to file for a PRETREATMENT ESTIMATE, so that your insurance company can provide an estimate of what they will pay for your necessary treatment.
5. We know questions will arise concerning insurance matters. We encourage you to discuss any questions with our staff. We hope you get some assistance from your insurance company but remember your insurance contract is between you and your insurance company.
6. NOTE: Medicare does not cover any procedure in this office.

Patient Signature_____ Date _____

Approved By_____

Privacy Agreement

*** Please initial after you read each of the following:**

*_____ I understand that my healthcare information concerning my diagnosis, treatment, payment and insurance will be disclosed when necessary for filing my insurance and in communicating with other health professionals in the course of my treatment at their offices. Limited information will also be disclosed to businesses supporting the operations of this office such as dental or medical labs, hospitals, accountant, computer support, billing personnel and consultants. These businesses are restricted in the use and disclosure of your information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose information to that family member or person.

*_____ I understand that my files are computer based records. Only staff may have access to this office during non-business hours. This office will make every effort to keep my information secure and correct any violation of your privacy if this should occur.

*_____ I understand that I have the right to access, copy or inspect and correct my healthcare information, the right to restrict disclosures and obtain an accounting of disclosures and to voice my concerns to the practice and/or the Secretary of Health and Human Services within 180 days of my discovery of a problem or a breach or violation of disclosure without fear of retaliatory acts by this office. Any correction to my records would be in the form of a note or letter signed by me. I also have the right to revoke my consent or authorization for disclosure.

*_____ I understand that I will receive communication in the form of phone calls and emails to remind me of an existing appointment, time to schedule an appointment or mail containing financial information, such as ledgers or bills. Communication may also be sent to me in the forms of fax or e-mails or other electronic means. I understand that if a message is left for me to return a call, the message will contain the doctor's name, phone number, date and time of appointment only.

I have read and understand this office policy. I understand that by signing this agreement, I give my permission to use and disclose my personal and health information to carry out treatment, payment activities and health care operations. This office retains the right to revise the privacy policy.

Patient Signature _____ Date _____

- o I have read this form and do **NOT** wish to sign. _____ (Please initial)