Berger Dental
1010 North Elm, Suite A
Denton, TX 76201

940.566.1828
fax - 940.566.3915

WELCOME

We are glad to have you as a new patient. At Berger Dental, we are committed to providing our patients with the finest dental care in a comfortable, service-oriented environment. Our goal is to provide total service – this includes quality dental care, easily understood education about your teeth and your particular oral condition or circumstances, efficient and thorough assistance with your billing and other business matters, timely follow up and communication on both your treatment schedule and your periodic hygiene visits and assistance with deciphering complex insurance issues.

The following forms need to be completed. Please fill them out completely and legibly. The information contained is critical to the quality of your care at our office. I strongly urge you to read all forms and ask about anything you do not understand completely.

We thank you for allowing us to serve your dental needs.

Sincerely,

Shane T. Berger

Shane T. Berger, D.D.S.

Enclosures
- Medical Info Form
- HIPAA Form
- Authorization Form

SHANE T. BERGER, D.D.S.

WELCOME TO OUR DENTAL CARE FAMILY

Please help us to get to know you

Patient Information

Miss/Ms/Mrs/Mr. _____
(Circle One) First Middle Initial Last

Address _____
Number & Street City State Zip

Phone(s) _____ _____ **DOB:** _____
Work # Home # Month Day Year

Social Security # _____ **DL#** _____

In the event of an emergency, who should we contact? Name: _____

Relation: _____ Work # _____ Home # _____

Whom may we thank for referring you? _____

Financial Information

Method of Payment: Cash/Check Visa/Mastercard/Discover Dental Insurance

Dental Insurance Co. _____

Employer _____

Person Responsible for Payment of Account: _____
(If Different From Above) First Middle Initial Last

Address: _____
Number & Street City State Zip

Medical Information

Have you been in the hospital in the past two years? Yes / No
If so, why? _____

Are you under the care of a physician now? Yes / No
If so, why? _____
Name of Physician:

Have you ever responded unfavorably to dental anesthesia or dental care? Yes / No
Please explain: _____

Are you taking any medications? Yes / No
List: _____

Are you allergic to any drug/medication? Yes / No
Latex gloves? Yes / No
List: _____

Do you have or have you had any of the following diseases or problems:

- ☐ Heart trouble, heart attack
- ☐ Stroke, high blood pressure
- ☐ Heart murmur, heart valve damage, replacement
- ☐ Rheumatic Fever
- ☐ Anemia, blood disorders, prolonged bleeding
- ☐ Asthma, hay fever
- ☐ Lung disease, bronchitis, emphysema
- ☐ Epilepsy, convulsions
- ☐ Hepatitis, jaundice, liver disease
- ☐ Blood thinners
- ☐ Kidney problems, renal dialysis
- ☐ Thyroid/gland problems
- ☐ Diabetes
- ☐ Cancer, tumors
- ☐ Do you smoke? Drink alcohol?
- ☐ Veneral disease, AIDS, HIV+
- ☐ Ulcer, stomach problems
- ☐ Joint Replacement
- ☐ Ever taken prescription diet pills? (Phen/Fen)
- ☐ Women: Are you pregnant?
- ☐ Do you have any problem, condition, disease not listed above? _____

Notes: _____

Reason for visit: ☐ Cleaning & Exam ☐ Emergency ☐ Other _____

What are your chief concerns regarding your teeth/oral health: _____

Signature of Patient _____ Date ___ / ___ / ___ Reviewed by _____ Date ___ / ___ / ___

Berger Dental

To All Our Patients…

In an effort to keep dental costs down while maintaining a high level of professional care we have established the following information for our patients. We encourage our patients to ask any questions they may have regarding our policies.

FINANCIAL POLICY

1. Payment in full at the time of visit is due unless prior financial arrangements have been made.
2. Payment may be made by cash, check, Visa, MasterCard, Discover, American Express, and check/debit cards. We have outside financing available including interest free payment plans.
3. Returned checks will add a $30.00 fee to your account. Replacement can be made by cash only.
4. We believe everyone's time is valuable, therefore, there will be a $25.00 fee charged for appointments cancelled or rescheduled without a 24 hour notice. Monday appointments require notice by 2:00 p.m. Thursday. Arrival for cleaning appointments 10 minutes (or more) late may require rescheduling.

All major treatments require an appropriate down payment. To avoid misunderstandings, our Business Manager will be happy to discuss any questions and/or financial concepts regarding fees and payments.

BILLING

An itemized statement covering all services received will be mailed on a monthly basis and will reflect the amount currently owed including any outstanding insurance. I understand that unpaid balances are subject to interest, 1.25% monthly, with a minimum of a $1.50 service charge. Unpaid delinquent balances are subject to interest and collection costs, including court costs and attorney fees. I understand that when appropriate, credit reports may be obtained.

INSURANCE

If you have dental insurance we will be happy to help you determine the coverage you have available. We estimate as closely as possible your co-payments; however, your insurance policy is a contract between you and your insurance company. We, therefore, cannot guarantee payment of your claims or accept the responsibility of negotiating claims with insurance companies or other persons. If your insurance company pays only a portion of the bill or rejects your claim, you are responsible for full payment for services rendered.

We allow 60 days for outstanding claims to be paid, after that, unpaid claim amounts are transferred to your personal balance and you are responsible for payment at that time. I fully understand that I am responsible for my charges at Berger Dental regardless of what my insurance company pays for any specific procedure and that I will immediately make up any difference between what I am charged and what my insurance company pays.

PLEASE READ THE FOLLOWING AUTHORIZATION AND SIGN FOR OUR FILES:

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand the use of anesthetic agents and other dental treatment embodies a certain risk. I authorized the release of any dental information and/or records. I authorize assignment of benefits on all claims, insurance or otherwise. I have read all of the above and agree to all terms and policies as outlined.

_____	_____	_____/_____/_____
Patient name	Signature	Date
_____	_____	_____/_____/_____
Parent or guardian of patient	Signature	Date

STATEMENT OF PRIVACY PRACTICES

We are dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act. This includes issues relating to your treatment, payment, and our dental care operations. You may give written authorization for us to disclose your information to anyone you choose, for any purpose but it will never otherwise be given to anyone – even family members – without your written consent.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all current and former patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone number(s), Social Security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, the information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. This includes issues in which we reasonably believe you may be a victim of abuse, neglect, domestic violence or other crimes. We are also obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to get copies of your healthcare information; to obtain copies in a variety of formats; and to a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can, also, notify the U.S. Department of Human Services.

We thank you for being a patient at our practice. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

BERGER DENTAL, P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Shane T. Berger

Telephone: 940.566.1828 Fax: 940.566.3915

E-mail: _____

Address: 1010 N. Elm, Suite A, Denton, Tx 76201

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

X Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.