



STEVEN G. BERWITZ
DMD

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____ Email: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
Address: _____
Street Apartment #
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment
Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

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.

A service charge of 1½% 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 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, or within five (5) days of billing if credit shall be extended. 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 not 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 my work to discuss matters related to this form.

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

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Date: _____ Relationship to Patient: _____

No Show Policy

It is the policy of Steven G. Berwitz, DMD, P.C. to optimize the use of treatment time by working to ensure that scheduled time blocks are filled by scheduled patients. We understand that situations arise when you need to cancel an appointment. However, patients who do not provide the office with at least 24 hours' notice of cancellation will be charged a \$50.00 "No-Show" fee for missing a confirmed appointment.

Steven G. Berwitz, DMD, P.C. reserve the right to discontinue patient care when an established patient misses three (3) confirmed appointments without providing one business day notice of cancellation. Established patients will be notified in writing that a third missed appointment will result in termination of the physician/patient relationship. When a new patient misses two (2) confirmed appointments, that patient will not be rescheduled. Thank you for your cooperation.

Patient Signature: _____ **Date:** _____

HIPPA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of the Notice of Privacy Practices; containing a more complete description of the uses and disclosures of my health information (available in office in print form or on the office website <http://www.stevenberwitzdmd.com>). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Legal Representative to Patient: _____

Health History Form



American Dental Association
www.ada.org

E-mail: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

| | | |
|-----------------------------|---|---|
| Name: Last First Middle | Home Phone: <i>Include area code</i> () | Business/Cell Phone: <i>Include area code</i> () |
| Address: Mailing address | City: | State: Zip: |
| Occupation: | Height: | Weight: Date of birth: Sex: M F |
| SS# or Patient ID: | Emergency Contact: | Relationship: Home Phone: Cell Phone: () () <i>Include area codes</i> |

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)* **Yes No DK**

Active Tuberculosis.....

Persistent cough greater than a 3 week duration.....

Cough that produces blood.....

Been exposed to anyone with tuberculosis.....

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information For the following questions, please mark (X) your responses to the following questions.

| Yes No DK | Yes No DK |
|---|--|
| Do your gums bleed when you brush or floss? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you have earaches or neck pains? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Are your teeth sensitive to cold, hot, sweets or pressure? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you have any clicking, popping or discomfort in the jaw? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Does food or floss catch between your teeth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you brux or grind your teeth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Is your mouth dry? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you have sores or ulcers in your mouth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Have you had any periodontal (gum) treatments? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you wear dentures or partials? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Have you ever had orthodontic (braces) treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you participate in active recreational activities? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Have you had any problems associated with previous dental treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Have you ever had a serious injury to your head or mouth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Is your home water supply fluoridated? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Date of your last dental exam: |
| Do you drink bottled or filtered water? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | What was done at that time? |
| If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY | Date of last dental x-rays: |
| Are you currently experiencing dental pain or discomfort? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | |
| What is the reason for your dental visit today? | |
| How do you feel about your smile? | |

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

| Yes No DK | Yes No DK |
|---|--|
| Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Physician Name: _____ Phone: <i>include area code</i> () | If yes, what was the illness or problem? |
| Address/City/State/Zip: | |
| Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: |
| If yes, what condition is being treated? | _____ |
| Date of last physical exam: | _____ |
| | _____ |
| | _____ |

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

| | |
|--|---|
| <p>(Check DK if you Don't Know the answer to the question)</p> <p>Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date Treatment began: _____</p> | <p>Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Number of weeks: _____ Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> |
|--|---|

| | |
|--|--|
| <p>Allergies - Are you allergic to or have you had a reaction to: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Metals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Latex (rubber) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Iodine _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Hay fever/seasonal _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Animals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Food _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> |
|--|--|

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

| | Yes | No | DK | | Yes | No | DK |
|---|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Artificial (prosthetic) heart valve | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Previous infective endocarditis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged valves in transplanted heart | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Systemic lupus erythematosus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart disease (CHD) | | | | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Unrepaired, cyanotic CHD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Repaired (completely) in last 6 months | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Empysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Repaired CHD with residual defects | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i> | | | | Cancer/Chemotherapy/ Radiation Treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiovascular disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain upon exertion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arteriosclerosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Type I or II | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Congestive heart failure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged heart valves | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Malnutrition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | G.E. Reflux/persistent heartburn | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other congenital heart defects | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | | |

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No DK
Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

