



STEVEN G.
BERWITZ, D.M.D

Cosmetic and Restorative Dentistry

7805 Waters Avenue • Suite 1A • Savannah Ga • 31406

The Smart Choice. . .

Dr. Berwitz's specific credentials in cosmetic and general dentistry and years of experience in these fields have made one practice the smart choice of thousands of patients in the Coastal area- from business people, soccer moms to retirees.

Let us welcome you, it's what we do best!

We invite you to visit our website at www.stevenberwitzdmd.com



May we ask how you found out about us? _____

PLEASE PRINT:

Patient's name _____ SSN# _____ Date of birth _____

Patient's Address _____ City _____ Zip _____

Home phone _____ Cell# _____

E-mail address _____

Employment _____ Work phone _____ Ext _____

Address _____

Spouse/ Parent _____ SSN# _____ Date of birth _____

Employed by _____ Work phone _____ Ext _____

Dental Insurance Co. _____ Phone# _____ Self _____ Spouse _____

Insurance Address _____

Member ID# _____ Group# _____

IN CASE OF AN EMERGENCY, please contact _____

Relationship to patient _____

Address _____ Home Phone _____

Other Phone _____

What is the reason for your visit today? _____

Are you having any discomfort at this time? _____

Is there anything you would like to change about your smile? _____

What obstacles may prevent you from maintaining healthy teeth and gums?

TIME/ COST/ FEAR of PAIN/ OTHER

To make your visits more enjoyable

- Many patients choose to be sedated for "Sleep Dentistry"
- We have Nitrous Oxide/ laughing gas
- We use a computerized anesthetic delivery system to make numbing more comfortable.
- We have a large selection of music available to enjoy
- Our hygiene chairs have massage pads for our comfort
- We offer bottled water, coffee and juice

CONSENT:

This is to certify that I, the undersigned, consent to the performing of dental procedures mutually agreed to be necessary or advisable, including the use of a sedative or local anesthetic as indicated and I will assume responsibility for fees associated with those procedures. I hereby authorize the release of my dental records to any dental office to which I am referred for treatment by Dr. Berwitz or to any designated person at the patient's personal request.

PATIENT'S (PARENT'S) SIGNATURE _____ **TODAY'S DATE** _____

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

(Check DK if you Don't Know the answer to the question)			Yes No DK				Yes No DK				
Do you wear contact lenses?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications? _____						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED					
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"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____					
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____					
Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.			Yes No DK				Yes No DK				
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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				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"/>	Emphysema			<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"/>
			Yes No DK				Yes No DK				Yes No DK
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"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice or liver disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection: _____					
Fainting spells or seizures.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____						Osteoporosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/ migraines			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____						Severe or rapid weight loss			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of infection: _____						Sexually transmitted disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Osteoporosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Persistent swollen glands in neck			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Severe headaches/ migraines			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Severe or rapid weight loss			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Sexually transmitted disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Excessive urination.....			<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?											
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?											
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: _____



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

This information is required by HIPPA (Health Insurance Portability and Accountability Act)

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ E-mail: _____
Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ 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 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, by contacting:

Rebecca Beasley Phone: 912.355.5004 Fax: 912.525.1973 Email: www.cookdds.com
Address: 7805 Waters Avenue, Suite 1A, Savannah, Georgia 31406

Right to Revoke: You will have the right to revoke this Consent at any time 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.

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 health care operations.

SIGNATURE: _____ **DATE:** _____

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

Personal Representative's Name: _____



CONSENT FOR TREATMENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of

Name of Patient _____

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and the other medication as necessary. I fully understand that using anesthetic agent embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's designated staff's use and disclosure of an oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice full outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) per month may be added to my account.

Patient (guardian) signature

Date



For Our Special Patients With Dental Insurance Coverage

As a courtesy to you, we will file your insurance claims on your behalf and assist you in maximizing your benefits. We encourage everyone to understand the coverage that your dental insurance provides. We realize that it is difficult to know exactly what your insurance company will pay toward procedures. We will do our best to estimate what your insurance company will pay based on the information you provide us. **Estimates are rarely 100% accurate and guaranteed.**

There are times when the insurance company may tell you that the charges incurred by you are more than the policy allows or that the procedures that were completed could have been accomplished using a cheaper and more inferior alternative. That is your insurance company's way of limiting your benefits and increasing their profits.

We expect the primary insurance company to pay claims within 30 days. Also, if you are fortunate enough to have a secondary dental insurance we can file that claim as well. However, we must have an EOB (Explanation of Benefits) and a check from the primary insurance before we can submit the secondary claim. If your primary insurance company does not pay, the current balance becomes your personal responsibility. Any delays in payment could result in finance charges applied to this balance.

I fully understand the above information and have been given the opportunity to have all my questions about handling insurance answered. I agree to the above terms and agree not to hold Steven G. Berwitz, DMD responsible for insurance discrepancies.

Patient Signature

date

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patients chart.

***PLEASE FILL OUT IF REQUESTING A COPY**

I, _____ have received a copy of this office's
Notice of Privacy Practices.

Please Print Name

Signature

Date



Records Release Request

(If applicable)

Date _____

To _____

Address _____

City _____ State _____ Zip _____

I authorize the release of dental record and x-rays and request they be sent to Steven G. Berwitz, DMD

(Print name)

(Sign name)