325 University Ave.
Syracuse, NY 13210
(315) 476-3552

Patient Name _____ **Date** _____ **E-Mail Address** _____

MEDICAL HISTORY

ARE YOU NOW OR HAVE YOU RECENTLY BEEN UNDER A DOCTORS CARE? YES NO REASON:

NAME OF PHYSICIAN: PHONE #: (_____) _____-_____

HAVE YOU EVER HAD ANY SERIOUS ILLNESS? YES NO EXPLAIN:

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?

RELATIONSHIP: HOME PHONE: WORK PHONE:

PLEASE NOTE ANY AND ALL MEDICAL ALERTS:
ARE YOU REQUIRED TO TAKE PRE-MEDICATION BEFORE DENTAL APPOINTMENTS? YES NO

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR SUSPECTED HAVING

YES	NO		YES	NO		YES	NO	
___	___	CHEST PAIN	___	___	HIGH BLOOD PRESSURE	___	___	HAY FEVER
___	___	HEART TROUBLE	___	___	LOW BLOOD PRESSURE	___	___	DIABETES
___	___	HEART MURMUR	___	___	SINUS TROUBLE	___	___	EPILEPSY
___	___	RHEUMATIC FEVER	___	___	THYROID DISEASE	___	___	GLAUCOMA
___	___	HEPATITUS OR JAUNDICE	___	___	SHORTNESS OF BREATH	___	___	HIV OR AIDS
___	___	PROLONGES BLEEDING	___	___	KIDNEY TROUBLE	___	___	LUNG DISEASE
___	___	BLOOD TRANSFUSION	___	___	BLADDER TROUBLE	___	___	EATING DISORDER
___	___	BLOOD DISEASE	___	___	LIVER DISEASE	___	___	ANEMIA
___	___	TUBERCULOSIS	___	___	VENEREAL DISEASE	___	___	STOMACH PROBLEMS
___	___	FAINTING SPELLS	___	___	MENTAL DISORDERS	___	___	LATEX ALLERGIES
___	___	RADIATION TREATMENT	___	___	ARTHRITIS			
___	___	JOINT REPLACEMENT	___	___	STROKE	OTHERS: (PLEASE LIST)		
___	___	CANCER OR TUMOR	___	___	ASTHMA			

MEDICATIONS

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES NO

IF YES, PLEASE LIST ALL:

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

IF YES, PLEASE LIST ALL:

WOMEN ONLY: ARE YOU PREGNANT? YES NO IF YES, HOW FAR ALONG?

ARE YOU CURRENTLY BREASTFEEDING? YES NO

I AUTHORIZE THE DOCTOR TO PERFORM SUCH DIAGNOSTIC AND THERAPEUTIC PROCEDURES AND ADMINISTER SUCH MEDICATIONS AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I ATTEST THE INFORMATION ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE:	SIGNATURE OF PATIENT (PARENT OF MINOR)	DOCTOR INITIALS
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____

325 University Ave.
Syracuse, NY 13210
(315) 476-3552

Please complete all sheets and return to the front desk. Thank you.

PATIENT INFORMATION		
NAME: LAST	FIRST:	MIDDLE:
ADDRESS:		
CITY:	STATE:	ZIP:
BIRTHDATE: ____/____/____ AGE:	SS#: _____-____-_____	MARITAL STATUS: S/M/D/W
EMPLOYER:	OCCUPATION:	
PHONE: HOME # ( ) -	WORK # ( ) -	CELL # ( ) -
PERSON RESPONSIBLE FOR BILL (IF DIFFERENT FROM ABOVE INFORMATION)		
NAME: LAST	FIRST:	MIDDLE:
ADDRESS:		
CITY:	STATE:	ZIP:
BIRTHDATE: ____/____/____ AGE:	SS#: _____-____-_____	MARITAL STATUS: S/M/D/W
EMPLOYER:	OCCUPATION:	
PHONE: HOME # ( ) -	WORK # ( ) -	CELL # ( ) -
PRIMARY DENTAL INSURANCE		
INSURED FULL NAME:		BIRTHDATE: _____/_____/_____
RELATIONSHIP TO PATIENT:		SS#: _____-____-_____
EMPLOYERS NAME:		EMPLOYERS PHONE: ( ) _____-_____
EMPLOYERS ADDRESS:		
CITY:	STATE:	ZIP:
INSURANCE CO. NAME:	GROUP #:	PLAN #:
INSURANCE CO. ADDRESS:		INS. CO. PHONE:
CITY:	STATE:	ZIP:
SECONDARY DENTAL INSURANCE		
INSURED FULL NAME:		BIRTHDATE: _____/_____/_____
RELATIONSHIP TO PATIENT:		SS#: _____-____-_____
EMPLOYERS NAME:		EMPLOYERS PHONE: ( ) _____-_____
EMPLOYERS ADDRESS:		
CITY:	STATE:	ZIP:
INSURANCE CO. NAME:	GROUP #:	PLAN #:
INSURANCE CO. ADDRESS:		INS. CO. PHONE:
CITY:	STATE:	ZIP:

GETTING TO KNOW YOU

1. WHOM MAY WE THANK FOR REFERRING YOU?

2. WHEN WAS YOUR LAST DENTAL VISIT
DATE OF LAST FULL SET OF X-RAYS:____/____/____

3. WHO WAS YOUR PREVIOUS DENTIST?
PHONE #: (_____) _____-_____

4. WHAT ARE YOUR PRIMARY DENTAL CONCERNS?

5. DO YOU HAVE ANY DISCOMFORT WHEN YOU CHEW OR BITE? YES NO
WHERE OR WHEN:

6. DO YOU HAVE ANY TEETH THAT ARE SENSITIVE TO HOT, COLD, SWEETS? YES NO
EXPLAIN:

7. ARE YOU HAVING ANY OTHER PROBLEMS? YES NO EXPLAIN:

8. HOW OFTEN DO YOU HAVE YOUR TEETH EXAMINED AND CLEANED?

9. HAVE YOU HAD MUCH DENTAL TREATMENT IN THE PAST? YES NO EXPLAIN:

10. DO YOU HAVE CONCERNS ABOUT THE DENTAL CARE YOU HAVE HAD IN THE PAST: YES NO
EXPLAIN:

11. ARE YOU MISSING ANY TEETH? YES NO
IF YES, DO YOU REGRET LOOSING THEM? YES NO

12. HAVE YOU EVER WORN BRACES? YES NO IF YES, WHEN? FOR HOW LONG?

13. DOES YOUR BITE FEEL COMFORTABLE? YES NO
CAN YOU CHEW AS WELL AS YOU WOULD LIKE TO? YES NO

14. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR SMILE/TEETH? YES NO
IF NO, WHAT IS IT THAT YOU WOULD LIKE TO CHANGE?

15. WHAT IS YOUR DAILY ORAL HYGIENE ROUTINE?
DO YOUR GUMS BLEED WHEN YOU BRUSH? YES NO

16. HOW OFTEN DO YOU SUFFER FROM BAD BREATH?
____RARELY _____OCCASIONALLY ____OFTEN

17. DO YOU USE GUM, BREATH MINTS OR COUGH DROPS?
____RARELY ____OCCASIONALLY ____OFTEN

18. HAVE YOU BEEN TOLD YOU HAVE GUM DISEASE? YES NO
HAVE YOU BEEN TREATED FOR GUM DISEASE? YES NO

19. DO YOUR JAW JOINTS EVER CLICK, POP, HURT, OR LOCK-UP? YES NO
HAVE YOU BEEN TREATED FOR "TMJ"? YES NO

20. WOULD YOU CONSIDER YOUR DAILY DIET TO BE: _____GOOD _____FAIR _____POOR?
DO YOU EXERCISE REGULARLY? YES NO

21. HOW MUCH OF A PRIORITY IS IT TO KEEP YOUR NATURAL TEETH?
___VERY HIGH ___SOMEWHAT HIGH ___LOW PRIORITY

22. HOW WOULD YOU RATE YOUR CURRENT DENTAL HEALTH?
____PERFECT ____GOOD ____FAIR ____POOR ____HOPELESS

23. HOW DO YOU FEEL ABOUT VISITING OUR OFFICE TODAY?
____EXCITED ____CONCERNED ____AFRAID ____TERRIFIED

24. IN WHAT AREAS WOULD YOU LIKE US TO ASSIST YOU? (PLEASE CHECK)
____CLEANING YOUR TEETH
____IDENTIFYING CURRENT PROBLEMS
____IDENTIFYING ISSUES WHICH ARE LIKELY TO BE PROBLEMS IN THE NEAR FUTURE
____WORKING WITH YOU TO CREATE LONG-RANGE STRATEGIES TO MAINTAIN THE HEALTH OF YOUR TEETH AND SMILE OVER YOUR LIFETIME
____WORK WITH YOU TO IDENTIFY WAYS TO IMPROVE THE APPEARANCE OF YOUR TEETH/SMILE

25. EXCESSIVE STRESS CAN NEGATIVELY INFLUENCE ALL ASPECTS OF OUR HEALTH. WHAT DO YOU FEEL ARE THE BIGGEST SOURCES OF STRESS YOU ARE FACING TODAY?

325 University Avenue
Syracuse, NY 13210
Phone: (315) 476-3552 Fax: (315) 479-0615

FINANCIAL POLICY

Welcome to Berry Good Dental Care, P.C. We want to make sure you have a clear understanding of our financial policy, and our expectations, so that you can make the best possible decision(s) about your dental care and treatment. Please read the policy carefully, and sign it prior to beginning treatment.

We are here to answer any questions you may have, so feel free to ask any questions of our staff. We look forward to providing you with pain-free, individualized, and high quality dental care.

- Full payment is expected at the time of service unless prior payment arrangements have been made.
- We accept cash, checks, Visa, MasterCard, Discover, and American Express.
- Currently, we are in network with Delta Dental, Blue Cross/Blue Shield, Pomco, CSEA, GHI, United Concordia, MetLife, and Guardian. Your co-payment will vary based on your plan coverage, and is due at the time of service.
- A 10% "Retiree" discount will be offered to those who qualify, and payment is made using cash or check.
- No discounts will be given on Credit Card payments, due to the fees we incur in processing.
- We have available to those who qualify, **CareCredit** for those in need of comprehensive treatment.
- Accounts 60 days past due will incur billing and finance charges of 12% APR.
- Any account of 90 days maturity will be sent to our Collections Agency.
- In the event that an account is referred to our Collections Agency, Berry Good Dental Care shall be entitled to recover reasonable collection costs along with the balance that is owed.
- As a courtesy to our patients, we will submit your insurance claim to your insurance company. However, you must inform us immediately of all changes to your policy.
- We will allow your insurance company 45 days to process and remit payment on submitted claims. After 45 days, the balance due for charges incurred to your account is your responsibility. Any follow up to your insurance company regarding unpaid claims, is your responsibility. We will assist you as best we can.

- We do require that our patients pay their portion of the fee at the time of service. We will estimate your portion due based on the information we obtain through a pre-estimate of benefits. Please understand that there is NO GUARANTEE OF INSURANCE BENEFITS, except for the ACTUAL PAYMENT itself. Ultimately, the patient is fully responsible for ALL CHARGES not covered by their policy. If we participate with your insurance plan, we will do the normal adjustments to your account before we bill you.

- Our Cancellation Policy states that appointment times are reserved specifically for you. Should the appointment need to be changed for some unforeseen reason, we require no less than 24 hours notice. Failure to comply with this will result in a $25.00 charge, which is subject to the same finance charges and collections previously stated.

_____

I have read this Financial Policy and understand and agree to its contents.

_____ _____

Signature of patient/Responsible party Date

I consent to the release of charges and other information necessary to process my insurance claims.

_____ _____

Signature of patient/responsible party Date

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: ___/___/_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health information (PHI) his been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.