Marc Berger
Choice Dentistry
AT WOODROW

803-888-2012

PATIENT INFORMATION

Today's Date: _____

Preferred Name: _____

Last: _____ First: _____ Middle: _____ ☐Mr. ☐Mrs. ☐Dr. ☐Other

Date of Birth: _____ Age: _____ SSN # _____ Marital Status: _____

Mailing Address

Street: _____ Apt # _____

City: _____ State: _____ Zip: _____

Email: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Employer: _____ Job Title: _____

Emergency Contact: _____ Phone # _____

How did you hear about our office?

☐ Family ☐ Friend ☐ Online Whom may we thank for referring you? _____

INSURANCE INFORMATION

You may skip this section if we have received your insurance information prior to appointment.

Subscriber's Address (if different from above): _____

Subscriber's Phone (cell): _____ Alternate Phone: _____

Group # _____ ID # _____

MEDICAL HISTORY

Do you now, or have you ever had any of the following? (Please check all that apply.)

- ☐ AIDS/HIV
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Spleen Removal
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Implants
- ☐ Asthma
- ☐ Beta Blocker
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Breast Cancer
- ☐ Cephalosporin Allergy
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Dialysis
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Erythromycin Allergy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Heart Attack/Angina
- ☐ Heart Murmur
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Motrin Allergy
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Osteomalacia
- ☐ Osteonecrosis of the Jaw
- ☐ Pacemaker
- ☐ Paget's Disease
- ☐ Penicillin Allergy
- ☐ Radiation Treatment
- ☐ Respiratory Issues
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Sulfur Allergy
- ☐ Tetracycline Allergy
- ☐ Thrombocytopenia
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors

Please record any conditions/diseases not listed: _____

Are you currently under medical treatment? ☐ No ☐ Yes, please explain: _____

Do you use tobacco products? ☐ No ☐ Yes

Do you take Blood Thinners? ☐ No ☐ Yes, please explain: _____

Are you currently taking any non-prescription medication? ☐ No ☐ Yes, please explain: _____

Please list your current prescriptions or provide a copy of your current list of medications: _____

_____

Please check if you are allergic or have had any reactions to the following:

- ☐ Aspirin
- ☐ Codeine
- ☐ Penicillin
- ☐ Barbiturates
- ☐ Late x
- ☐ Sulpha Drugs
- ☐ Local Anesthetics (i.e Novocaine)
- ☐ Any metal (i.e Nickel, Mercury , etc)
- ☐ Other: _____

Do you take or have you ever taken any of the following medications or any other Bisphosphonate Medications?

- ☐ Zometa
- ☐ Aredia
- ☐ Fosama x
- ☐ Boniva
- ☐ Actone
- ☐ Didronel
- ☐ Skelid
- ☐ Prolea

Women Only:

Are you pregnant or suspect that you may be pregnant? ☐ No ☐ Yes

Are you nursing? ☐ No ☐ Yes

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Marc Berger Choice Dentistry to use or disclose my Protected Health Information as described below.

I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Today's Date: _____

Patient Name: _____

Name of Person(s) Authorized to **RECEIVE** the Information: _____

I, _____ ,understand that by signing this Consent form, I am giving my consent to Marc Berger Choice Dentistry to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

_____

Name:

_____

Relationship:

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 Compliance Officer

_____ _____

Patient's Signature (Legal Guardian, if Patient is a minor) Date

Information to be used/disclosed:

☐ Complete Chart ☐ X-Rays ☐ Clinical Notes ☐ Billing Summary ☐ Procedure Summaries

FINANCIAL POLICY

Full payment is due at the time services are rendered. In the event that a balance exists after an appointment, said balance must be paid within 30 days unless prior arrangements have been made. We realize that temporary financial problems may affect timely payment on an account. If such problems arise, it is the patient's responsibility to contact our billing department promptly for payment arrangements and assistance in management of the account. Any balance remaining after 60 days is subject to referral to collections agency. Patient/Guarantor will be responsible for any costs incurred if account is turned over to a collection agency, including collection fees, attorney fees, and any other associated court costs.

RESPONSIBLE PARTY

Person responsible for payment if patient is minor/under the age of 18.

Your Name: _____

Mr. Mrs. Miss Relationship to patient _____ Date of Birth: _____

SSN # _____

MAILING ADDRESS

Email: _____ Cell Phone: _____

Home Phone: _____

Employer: _____ Job Title: _____

Work Phone: _____

I, _____ have read, understand and agree to the Marc Berger Choice Dentistry Financial Policy.

Patient/Guarantor's Signature:_____Date: _____

Print Name: _____

We request 24 hours advance notice for all cancelled appointments. Any cancellations made with less than 24 hours notice may be subject to a $50 cancellation fee per appointment. If you fail to show up to your appointment without notifying our office, you may be subject to a $50 missed appointment fee.

ACKNOWLEDGEMENT OF RECEIPTOF NOTICE OF PRIVACY PRACTICES CONSENT FORUSE AND DISCLOSURE OF HEALTH INFORMATION

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 OPERA TIONS.

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 healthcare information, and of other import ant 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.

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 on this form. 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 the 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 health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT ONCE SIGNED

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our office at: Telephone (803) 888-2012 Fax (803) 888-4695
Email: julieberger@mbchoicedentistry.com Address: 928 Woodrow St, Columbia, SC 29205

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____

Pharmacy Information

Current Pharmacy _____

Pharmacy Address _____

Pharmacy Phone Number _____