

Dr. Ronald Berris D.D.S.,P.C.
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Dr. Douglas Shiffman, D.D.S.

Confidential Patient Registration & History

6400 Farmington Rd. • West Bloomfield MI • 48322 • (248) 661-4000

account #

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|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

General Information

Title Mr. Mrs. Ms. Dr. Other _____

Name _____ Birthdate ____/____/____ Sex M F

Social Security No. ____/____/____ Student Marital Status Single Married Divorced Widowed

Address _____ City _____ State _____ Zip _____

Home# (____) _____ Work# (____) _____ Cell Phone (____) _____

E-mail _____

If student, name of school _____ Are you eligible for insurance? Yes No

Referred by _____

Emergency Contact (name & number) _____

Information of Person Responsible For Payment

Name _____ Self Spouse Dependent

Address _____ City _____

State _____ Zip _____ Phone (____) _____ Phone (alt) (____) _____

Employer _____ Position _____ Yrs. Employed _____

Business Address _____ City _____

State _____ Zip _____ Phone (____) _____ ext _____ Phone (alt) (____) _____

Social Security No. ____/____/____ Driver's License No. _____

Credit Card No. _____ exp. date _____

Dental Insurance Information

Primary Insurance Company _____ Group No. _____

Subscriber's Name _____ Birthdate ____/____/____

Social Security No. ____/____/____ or Alternate I.D.# _____

Employer _____ Bus. Phone (____) _____ ext _____

Business Address _____

Patient's Relationship to Subscriber Self Spouse Dependent

Does your insurance have Coordination of Benefits? Yes No

Secondary Insurance Company _____ Group No. _____

Subscriber's Name _____ Birthdate ____/____/____

Social Security No. ____/____/____ or Alternate I.D.# _____

Employer _____ Bus. Phone (____) _____ ext. _____

Business Address _____

Patient's Relationship to Subscriber Self Spouse Dependent

Are you familiar with your insurance company's dental plan? Yes No

To insure and provide accurate treatment, all information must be completed.

Confidential Dental History

1. What is your initial concern/ or chief dental complaint? _____

2. Are you experiencing any pain or discomfort at this time? _____ yes no
3. How long ago was your last dental appointment? _____ What was done? _____
4. Previous dentist _____ Phone _____
Address _____
5. When was the last time you had a complete series of X-rays? _____
6. Duration between your teeth cleanings? ___ 3mo ___ 4mo ___ 6mo Last cleaning date _____
7. How often do you brush your teeth? _____ times a day. Floss your teeth? _____
8. Does food catch between your teeth? ___ yes ___ no If so, where? _____
9. Do your gums ever bleed? When? _____ yes no
10. Have you noticed any bad odors or tastes from your mouth? _____ yes no
11. Are you aware that loss of bone supporting your teeth may occur without obvious symptoms? _____ yes no
12. Have you noticed any loose teeth? _____ yes no
13. Are your teeth sensitive to hot, cold, chewing, or sweets? _____ yes no
14. Do you have pain in the area in front of your ear? _____ yes no
15. Do you clench or grind your teeth in the daytime or at night? _____ yes no
16. Does your jaw pop or click when you open or chew? _____ yes no
17. Check any of the following which you have had or have at the present:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> TMJ / MPD Diagnosis | <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Bleaching |
| <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Pain in Jaw | <input type="checkbox"/> Bite Plate / Guard | <input type="checkbox"/> Laminates / Bonding |
| <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Bite Adjusted | <input type="checkbox"/> Cold Sores or Blisters |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Bridges | <input type="checkbox"/> Dental Phobia |
| <input type="checkbox"/> Root Canals | <input type="checkbox"/> Trauma to Head | <input type="checkbox"/> Crowns | <input type="checkbox"/> Partial / Complete Dentures |

18. Do you have any problems or dislikes associated with your previous dental treatment? _____
 19. How do you react to Dental care? _____ Dread it? ___ Worry about it ___ Don't mind it ___ Love it!!! _____
 20. Has financial obligation in the past limited your acceptance of ideal dental treatment _____ yes no
 21. My mouth is _____ comfortable ___ moderately comfortable ___ uncomfortable
 22. Are you satisfied with the appearance of your teeth? _____ yes no
 23. Would you like to improve the appearance of your teeth? _____ yes no
- If yes, please indicate what you would like to change:
- Size Shape Spacing Alignment Color

Parents:

If there is a need, may we:

- | | |
|---|---|
| Use local anesthetic on your child? ___ yes ___ no | Administer nitrous oxide to your child? ___ yes ___ no |
| Apply fluoride at each checkup? ___ yes ___ no | Take x-rays as needed? ___ yes ___ no |

Child's nickname _____ Child's Hobbies _____

Signature _____ Date _____

WE REQUEST THAT YOU REMAIN IN OUR OFFICE WHILE YOUR CHILD IS BEING TREATED

Confidential Patient Medical History

1. Are you in good health? _____ yes no
2. Has there been any change in your general health within the year? _____ yes no
3. My last physical exam was on (approx. date) _____
4. Have you been a patient in the hospital during the past two years? _____ yes no
5. Have you been under the care of a medical doctor during the past two years? _____ yes no

Physician's Name _____
 Address _____ Phone No. _____

6. Are you taking any medications now? _____ yes no

| Current Medication | Reason: | Current Medication | Reason: |
|--------------------|---------|--------------------|---------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Additional space on back page

7. Do you take aspirin daily? How much? _____ yes no
8. Are you allergic or have you reacted adversely to any of the following? _____ yes no

- | | | | |
|---------------------|-----------------|----------------------|----------------------|
| __ Aspirin | __ Penicillin | __ Other Antibiotics | __ Dental Anesthetic |
| __ Darvon | __ Erythromycin | __ Iodine | __ Latex / Vinyl |
| __ Codeine | __ Tetracycline | __ Nitrous Oxide | __ Foods |
| __ Motrin/Ibuprofen | __ Sulfa | __ Anesthetic | _____ |

9. Are you aware of being allergic to any other medications or substance? _____ yes no
 If yes, please list: _____
10. Are you ever short of breath or exhibit chest pains upon mild exertion? _____ yes no
11. Do you urinate more than six times a day? _____ yes no
12. Are you on a special diet? _____ yes no
13. Do you smoke? _____ Packs per day _____ Number of years _____ yes no
14. Do you drink alcohol? _____ How much per week? _____ yes no

15. Check any of the following which you have had or have at present:

- | | | |
|------------------------------|------------------------------------|---------------------------------|
| __ Heart Disease / Attack | __ Emphysema | __ A.I.D.S. / HIV+ |
| __ Angina Pectoris | __ Persistent Cough | __ Hepatitis A (Infectious) |
| __ Prolapse Mitral Valve | __ Tuberculosis (TB) | __ Hepatitis B (Serum) |
| __ High/Low Blood Pressure | __ Asthma | __ Hepatitis C / D |
| __ Prolonged Bleeding Time | __ Hay Fever | __ Liver Disease |
| __ Heart Murmur | __ Sinus Trouble | __ Alcoholism |
| __ Congenital Heart Lesions | __ Allergies or Hives | __ Drug Addiction |
| __ Scarlet / Rheumatic Fever | __ Diabetes | __ Hemophilia / Blood disorders |
| __ Artificial Heart Valve | __ Thyroid Disease | __ Venereal Disease |
| __ Heart Pacemaker | __ Radiation Treatment | __ Cold Sores / Blisters |
| __ Heart Surgery | __ Chemotherapy (Cancer, Leukemia) | __ Blood Transfusion |
| __ Stents | __ Arthritis | __ Epilepsy or Seizures |
| __ Anemia | __ Rheumatism | __ Fainting or Dizzy Spells |
| __ Stroke | __ Prolonged use of Steroids | __ Nervousness |
| __ Kidney / Bladder Trouble | __ Glaucoma | __ Psychiatric Treatment |
| __ Ulcers | __ Pain in Jaw Joints | __ Sickle Cell Disease |
| __ Artificial Joints | __ Blood Disorders | __ Bruise Easily |

16. Do you have any disease, condition, or problem not listed? _____ yes no

FOR WOMEN ONLY:

- Are you pregnant? If yes, what month? _____ yes no
- Are you nursing? _____ yes no
- Are you taking birth control pills? _____ yes no

Responsibility and Consent Statement

I hereby authorize and request the performance of dental services for myself or the person designated on this form. I also give consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by attending dentist or by his supervised staff for diagnostic or dental treatment. Records taken may include study models, photographs and blood studies. Additionally, the dentist needs a current full set of x-rays to accurately detect tooth decay and gum disease. I understand and acknowledge that I am financially responsible for the services provided for myself or the person designated by this form, regardless of insurance coverage. I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be notified of the need and its fee. Scheduling time is at a premium for all parties. **Therefore, as a courtesy, 24 hours prior notice is necessary to avoid a possible broken appointment charge.**

Signature of Patient _____ Date _____
Signature of Dentist _____ Date _____

For staff use

UPDATES TO MEDICAL HISTORY & MEDICATIONS:

DATE:

| | |
|-------|-------|
| _/_/_ | _____ |
| _/_/_ | _____ |
| _/_/_ | _____ |
| _/_/_ | _____ |
| _/_/_ | _____ |
| _/_/_ | _____ |
| _/_/_ | _____ |
| _/_/_ | _____ |
| _/_/_ | _____ |
| _/_/_ | _____ |

NOTES

FOR OFFICE USE ONLY

ACCOUNT TYPE:

- RB
- NB
- NA
- NI
- CD ___ %

Registration:

- Referral _____
- Medical _____
- Recall _____
- Insurance _____
- Alternate Address? _____

Messages:

Pre Med ___ yes ___ no

Registration Completed by _____ Date _____



RONALD BERRIS D.D.S., P.C.

6400 FARMINGTON ROAD – WEST BLOOMFIELD, MI 48322

PHONE 248-661-4000 FAX 248-661-4003

PATIENT CONSENT / ACKNOWLEDGMENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that our office comply with certain rules regarding the maintenance of your information that we have collected and will collect in the future. By signing below, you consent to the use and disclosure of your protected health information by RONALD BERRIS D.D.S., P.C., our staff, and our business associates for treatment, payment and health care operations.

For a more detailed description of uses and disclosures for these purposes, please request and review our Notice of Information Practices (“Notice”). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If they do, you may request a revised Notice by contacting this office (248) 661-4000. We will also post any revised notice in the office.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional or make disclosures of your information in connection with providing or coordinating your treatment. You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations. If we agree to further restrictions, they are binding on us. However, we are not required to agree to these restrictions. Finally, you may refuse to consent to the use or disclosure of your protected 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 Protected Health Information (PHI).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, am aware of and understand this office's Notice of Privacy Practices. I understand, that I may request a copy of this Notice.

Please Print Name _____ Signature **X** _____ Date _____

The above consent will apply to my children of record until they attain the age of 18.

For Office Use Only

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement Other (Please Specify)

COMPLIANCE FORM

Our office calls to confirm appointments. This courtesy is labor intensive, time consuming and often requires several calls in an effort to reach the patient in person. The majority of patients remember scheduled appointments and appreciate time reserved for their dental care. We appreciate your commitment and respect in honoring scheduling obligations. When a patient breaks or re-schedules their appointment, without sufficient notice, the doctor or hygienist treatment time is unproductive. **Office policy is to charge a fee for broken appointments. In some instances, a fee has been charged for re-scheduled or cancelled appointments without 24 hours notice.** This policy, because of our close patient relationship, has been difficult to implement and enforce. To reduce overhead costs and labor constraints, a change in appointment confirming is necessary. Improved efficiency requires shifting more responsibility to the patient.

For our new confirmation policy, we request that you indicate the Home and Office procedure necessary to confirm your appointments:

- Home telephone confirmation with patient only;
- Home telephone message with a family member;
- Home telephone message with answering machine;

- Business telephone confirmation with pt only; **wk #** _____
- Business telephone message with co-worker; **wk #** _____
- Pager or car phone confirmation with patient; **cell #** _____

- No telephone confirmation is necessary.

When our office abides by your request and you do not honor your agreement, **please respect our policy and need to charge a fee.** Our relationship is mutually important to provide sufficient time and effective business practices.

Please sign and date below. This form will be part of your permanent record.

(Patient Signature)

(Date)