Date_____ Name_____

Home Phone _____ Work Phone_____ Cell Phone_____

E-Mail Address_____

MailingAddress_____ Apt#_____

City_____ State_____ Zip_____

Patient's or Parent's Employer_____

Contact in Case of Emergency_____ Phone:_____

Insurance Information

Name of Insured_____ Relationship_____

Birth date_____ Social Security Number_____ Phone_____

Employer_____ Work Phone_____ Group Number_____

Insurance Company_____ Member ID Number_____

Insurance Co. Address_____ City/State/Zip_____

Additional Dental/Medical Insurance

Name of Insured_____ Relationship_____

Birthdate_____ Social Security #_____

Employer_____ Work Phone_____ Group Number_____

Insurance Company_____ Member ID Number_____

Insurance Co. Address_____ City/State/Zip_____

Yes	No	
☐	☐	1. Are you currently under medical treatment?
☐	☐	2. Within the last 5 years, have you ever been hospitalized for any surgical operation or serious illness? If so, please explain_____
☐	☐	3. Do you have a cardiac pacemaker?
☐	☐	4. Do you use tobacco products?
☐	☐	5. Do you use controlled substances?
☐	☐	6. Do you take blood thinners (i.e. COUMADIN, PLAVIX, PRADAXA, EFFIENT, BRILINTA)
☐	☐	7. Are you taking any non-prescription medication(s)? If so, please list _____
☐	☐	8. Do you take any prescription medication(s)? If so, please list or provide a copy of medications _____

9. Please circle if you are allergic to or have had any reactions to the following:

Aspirin	Any metals (e.g. nickel, mercury, etc)	Barbituates
Codeine	Local anesthetics (e.g. novocaine)	Latex rubber
Penicillin	Sedatives	Sulfa Drugs

Other:_____

10. Women only:

Are you pregnant or think you may be pregnant?_____

Are you nursing?_____

14. Do you have or have you had any of the following?

	Yes	No
HIV Disease	☐	☐
Dialysis	☐	☐
Heart Murmur	☐	☐
Kidney Diseases	☐	☐
Lupus	☐	☐
Mitral Valve Prolapse	☐	☐
Rheumatic Fever	☐	☐
Spleen Removal	☐	☐
Joint Replacement/Implant	☐	☐

	Yes	No
Allergies/Hay fever	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy/Convulsions	☐	☐
Crohn's Disease	☐	☐
Stomach Trouble/Ulcers	☐	☐
Glaucoma	☐	☐

	Yes	No
Heart Attack	☐	☐
Heart Disease/Angina	☐	☐
Hepatitis/Jaundice	☐	☐
High Blood Pressure	☐	☐
Liver Disease	☐	☐
Radiation Therapy	☐	☐
STD	☐	☐
Stroke	☐	☐
Thrombocytopenia	☐	☐
Thyroid Problems	☐	☐
Tuberculosis	☐	☐

Are you required by your physician to take an antibiotic before dental procedures?_____

Do you have or have you ever had a history of the following conditions:

	Yes	No
Multiple Myeloma	☐	☐
Metastatic Cancer	☐	☐
Breast Cancer	☐	☐
Lung Cancer	☐	☐
Paget's Disease	☐	☐
Osteoporosis	☐	☐
Osteomalacia	☐	☐
Osteonecrosis of the jaws	☐	☐

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

	Yes	No
Zometa	☐	☐
Aredia	☐	☐
Fosamax	☐	☐
Boniva	☐	☐
Actonel	☐	☐
Didronel	☐	☐
Skelid	☐	☐
Prolea	☐	☐

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. The fee for a returned check is $30.00

A service charge of 1 ½% 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 should this account be turned over to a collection agency for delinquency that a collection and/or attorney's fee of 30% and all related collection costs will be added to my outstanding balance and payable to the collection agency by me.

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.

I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

THERE IS A $40.00 CHARGE FOR APPOINTMENTS NOT CANCELLED OR RESCHEDULED AT LEAST 24 HOURS PRIOR TO APPOINTMENT TIME.

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

_____ **Date:**_____ **Relationship to Patient:**_____
Signature of patient, parent or guardian

_____ **Date:**_____ **Relationship to Patient:**_____
Signature of guarantor or payment/responsible party

MEDICARE / MEDICAID REPLACEMENT OR SUPPLEMENT PLANS

We are not network providers for Medicare, Medicaid or any policy replacing or supplementing them. We are therefore unable to file claims for reimbursement.

I understand that if I receive services from D Berger Dental of Elgin PA that I am responsible for payment in full at the time of service and that Medicare, Medicaid nor any supplement or replacement will be billed for reimbursement by D Berger Dental of Elgin PA. I agree that I will not file to Medicare, Medicaid nor any supplement or replacement to these policies.

☐ **I DO NOT HAVE ANY OF THESE POLICIES TO MY KNOWLEDGE.**
☐ **I HAVE ONE OF THESE POLICES BUT UNDERSTAND THAT IT WILL NOT BE FILED.**

PAYMENT IS DUE WHEN SERVICES ARE RENDERED.

Payment may be made by cash, check, debit card, or credit card (Visa, Master Card, American Express, and Discover, Care Credit). Payment for procedures not specifically covered or fully covered by an insurance carrier are due at the completion of each visit this includes deductibles and co-payments.

METHODS OF PAYMENT

PAYMENT IN FULL:

Payments are accepted for full payment the day of or prior to treatment. The insurance payment sent by your insurance company will go directly to the patient (guarantor).

ESTIMATE-PLUS PAYMENT PLAN:

Payment of the estimated Patient Portion, to cover any insurance shortfall in coverage, is to be paid at the time of treatment. The practice will then accept the insurance's payment and then bill any remaining balance if necessary, or refund any overpayment to the patient.

I assign my insurance benefits to the provider listed above. I understand this form is valid for one year unless I cancel the authorization through a written notice.

I understand it will be my responsibility to pay for any and all x-rays that my insurance company does not cover for whatever reason.

SIGNATURE_____ **DATE**_____