Welcome to the office of William R. Berry, III, D.D.S.

PATIENT INFORMATION

(This information is necessary for our files and is CONFIDENTIAL)

Date _____

Patient's Name _____ (LAST / FIRST / INITIAL) Age _____ Patient's Birthday _____

If patient is a minor, give name of parent or legal guardian _____ Relationship _____

Residence Address _____ (STREET / CITY / ZIP) For how long? _____ ☐ Own ☐ Rent

Patient is: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Driver's License No. _____ Social Security No. _____ Res. Phone ( ) _____

Bank _____ Account No. _____ Cell Phone ( ) _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ (STREET / CITY / ZIP) Bus. Phone ( ) _____

Spouse's Name _____ Driver's License No. _____ Soc. Sec. No. _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ (STREET / CITY / ZIP) Bus. Phone ( ) _____

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ (STREET / CITY / ZIP) Res. Phone ( ) _____

Name of Physician _____ (ADDRESS / CITY / TELEPHONE)

Former Dentist _____ (ADDRESS / CITY / TELEPHONE)

Purpose of Appointment _____

Is this office visit for Emergency Dental Care? ☐ Yes ☐ No If yes, explain: _____

School Children Attend _____ Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____

Address _____ (STREET / CITY / ZIP / TELEPHONE)

PREFERENCE OF PAYMENT: ☐ Cash on day of treatment ☐ Visa No. _____

☐ State Aid No. _____ ☐ Mastercard No. _____

Name of insurance company (primary insurance) _____

INSURED PERSON'S NAME _____ BIRTHDATE _____ RELATIONSHIP _____ SOCIAL SECURITY NO. _____

NAME OF GROUP DENTAL PLAN _____ GROUP NO _____ PLAN NO. _____ NAME OF UNION _____ LOCAL _____

Name of insurance company (secondary insurance) _____

INSURED PERSON'S NAME _____ BIRTHDATE _____ RELATIONSHIP _____ SOCIAL SECURITY NO _____

NAME OF GROUP DENTAL PLAN _____ GROUP NO. _____ PLAN NO. _____ NAME OF UNION _____ LOCAL _____

TERMS & CONDITIONS

As a condition of treatment by this office, I understand 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 be fore treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot rel[illegible] services on the assumption that charges will be paid by an insurance company.

Assignment of insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1 1/2% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the legal value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a wavier for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys' fees.

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

I have read the above conditions of treatment and agree to their content:

Signed: _____ Date: _____

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.
Please answer each question. Circle Yes or No where applicable. Example: Are you alive ..... (Yes) No

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Date of last physical examination _____
3. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? ..... Yes No
   If so, what illness or operation? _____
5. Have you ever been hospitalized? ..... Yes No
   If so, what was the problem? _____
6. Are you taking any medicine ☐ Yes ☐ No or any recreational drugs (marijuana, cocaine, etc.)? ..... Yes No
   If so, what? _____ What dosage? _____
7. Have you ever been pre-medicated with antibiotics for your dental treatment? ..... Yes No
8. Are you sensitive or allergic to any drugs? ☐ Penicillin; ☐ Tetracycline; ☐ Sulfa Drugs; ☐ Aspirin; ☐ Codeine ..... Yes No
   ☐ Other If Other, what drugs? _____
9. Do you have or have you had any of the following: (Please circle Y or N below)

Y N Anemia	Y N Cold Sores	Y N Sinus Trouble	Y N Blood Transfusion	Y N Pain in Jaw Joints	Y N X-Ray or Cobalt Treatment
Y N Herpes	Y N Hemophilia	Y N Blood Disease	Y N Joint Replacement	Y N Respiratory Disease	Y N Fainting Spells or Seizures
Y N Stroke	Y N Rheumatism	Y N Drug Addiction	Y N Nervous Disorders	Y N Sickle Cell Disease	Y N Chemotherapy (Cancer, Leukemia)
Y N Ulcers	Y N Heart Murmur	Y N Kidney Disease	Y N Tumors or Growths	Y N Tuberculosis (T.B.)	Y N Radiation Treatment of any kind
Y N Diabetes	Y N Bruise Easily	Y N Stomach Ulcers	Y N Allergies or Hives	Y N Epilepsy or Seizures	Y N Hepatitis or Jaundice
Y N Glaucoma	Y N Head Injuries	Y N Angina Pectoris	Y N Cortisone Medicine	Y N Artificial Prosthesis	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Arthritis	Y N Heart Failure	Y N Mental Disorder	Y N Excessive Bleeding	Y N Psychiatric Treatment	Y N Acquired Immune Deficiency Syndrome (AIDS)
Y N Emphysema	Y N Liver Disease	Y N Rheumatic Fever	Y N Asthma	Y N Congenital Heart Lesions	Y N TMJ (Temporomandibular joint)
Y N Hay Fever	Y N Scarlet Fever	Y N Thyroid Disease	Y N High Blood Pressure	Y N Difficulty in Swallowing	Y N Other: _____
Y N Tonsilitis	Y N Chicken Pox	Y N Cerebral Palsy	Y N AIDS Related Complex	Y N Heart Ailments or Attack	

10. Do you wear a cardiac pacemaker, or have you had heart surgery ..... Yes No
11. Do you have any disease, condition or problem not listed that you think I should know about? ..... Yes No
    If so, what? _____
12. Do you smoke? If yes, how much? _____ per day ..... Yes No
13. (Women) Are you pregnant? If so how many months ..... Yes No
14. (Women) Do you have any problems associated with your menstrual period? ..... Yes No
15. (Women) Do you take birth control pills? ..... Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc)? ..... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
   If so, explain _____
4. How long since your last full mouth X-Rays? _____
5. How long since your last dental treatment? _____
6. Does dental treatment make you nervous ..... Yes No
   If Yes, Check 4: ☐ Slightly ☐ Moderately ☐ Extremely
7. Would you desire to be pre-sedated? ..... Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date _____ Signature _____

Year 2
Changes in Health _____

Date _____ Signature _____

Year 3
Changes in Health _____

Date _____ Signature _____

Health Questionnaire MUST be updated every year!

REVIEWED BY DO NOT WRITE IN THIS AREA

	A	B	C
Date			
BP	/	/	/
Pulse			
Temp			
By			

A DATE
B DATE
C DATE

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form to administer such analgesics, sedatives and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof.

Signed: _____ **Date:** _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____

WELCOME TO OUR PRACTICE

This form is designed to acquaint you with our Office Policies. You have the opportunity to question, at this time and prior to service, the Office Policies and procedures in the following areas of concern. **PLEASE INITIAL EACH ITEM.**

___ This office employs licensed, board certified Dentist and Dental Assistants (DA) who will be involved in your care and providing your treatment.

___ Please note, our relationship is with you and not your insurance company or pharmacy.

___ Policy on Cancellation & Rescheduling (Need 48 hours) (*When you receive your reminder call*, you must call us back and let us know you received your reminder call.)

___ Failure to give 48 hours advance notice of cancellation will result in altered and specialized scheduling.

___ Patients are responsible to know their insurance benefits prior to first visit.

___ NSF checks recovers ($30.00) Recovery Fee (There after Cash Only.)

___ Statements are billed twice a month. Expectant payment is 10 days.

___ You must notify us of any changes in insurance, job, name, phone and address.

___ All established patient phone calls are designed to remind you of an appointment only.

___ Diagnostic and Treatment codes for billing will not be altered for insurance purposes.

___ Pharmacies: patients must supply the office with their pharmacy phone number.

___ Co-payment and Fee for Service is due at the time of service.

___ If pretreatment instructions have not been followed, your procedures may be cancelled.

___ 18 years and under must be accompanied by a parent or guardian.

___ You must have your current Medicaid Card to receive service.

___ Please ask about our "Patient Referral Incentive Plan."

My initial above and my signature below signifies I have read the above and understand the counseling I received.

Printed Name _____ Patient Signature_____ Date _____

FINANCIAL OPTIONS & GUIDELINES

This form is designed to notify you of our office policies regarding methods of payments we offer you, including acceptance of insurance.

METHOD OF PAYMENT

_____*CASH, CHECK or CREDIT CARD*
_____ *VISA, MASTERCARD ,AMERICAN EXP, DEBIT CARD*
_____ *THIRD PARTY FINANCING (CC) & (DFP) PLEASE ASK!*

OPERATIONAL POLICIES

Major Procedures require a deposit to hold the space and time that is completely dedicated for your treatment, therefore we must secure that space and time with a deposit that assures us you will be keeping that appointment.

INSURANCE RELATIONSHIP

We are very happy you have an insurance to assist you in the payment for these procedures, however, please know that our relationship is with you, our patient, not the insurance company. We bill and trace your insurance for payment, however you are ultimately responsible for payments.

PAYMENT AT THE TIME OF SERVICE

Payments are made at the time of services. Our patients appreciate taking care of their business with the front desk, prior to treatment and while waiting. This cuts down on the time they have to spend waiting at the end of service. Also while their comfort level is higher.

PLEASE SIGN_____**DATE**_____

HIPAA PRIVACY DOCUMENT

William R. Berry, III, D.D.S, P.C.
500 N. Monroe St.
Albany, GA 31701
(229) 435-4689

Notice of Privacy Practices

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

As our patient we respect the privacy of your personal medical records and we 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 in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

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 dentists not patients), and may have to disclose personal health information for purpose of treatment, payment or health care operations. These entities are generally not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal 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 all or part of yourPersonal Health Information (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) has been identified as a national problem causing patients inconvenience, aggravation, and financial problems. Our employees 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 Personal Health Information (PHI) in accordance with governmental rules, laws and regulations. We want to ensure that our 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 Personal Health Information (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. Furthermore, 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.

Dental Claim Form

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / /
29. Marital Status ☐Married ☐Single ☐Other
30. Sex ☐M ☐F

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X
Signed (Patient/Guardian) | Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32-37) ☐Yes: ☐Dental or ☐Medical | 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School Name Address
38. Subscriber/Employee Status ☐Employed ☐Part-time status ☐Full-time Student ☐Part-time Student
40. Employer/School Name Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X
Signed (Employee/Subscriber) | Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐Yes, How many?____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed | Total mos. of treatment remaining
55. If prosthesis(crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: — Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐No ☐Yes — Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither — Brief description and dates

58. Diagnosis Code Index (optional)
1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____ 7. ____ 8. ____

59. Examination and treatment plans - List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with "X"

Permanent									Primary								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A B C D E	F G H I J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T S R Q P	O N M L K

61. Remarks for unusual services

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X
Signed (Treating Dentist) | License # | Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code