Dr. Ronald Berris D.D.S.,P.C.
Dr. Julie Goldstein D.D.S.

Confidential Patient Registration & History

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

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:

__ Periodontal Treatment	__ TMJ / MPD Diagnosis	__ Missing Teeth	__ Bleaching
__ Orthodontic Treatment	__ Pain in Jaw	__ Bite Plate / Guard	__ Laminates / Bonding
__ Oral Surgery	__ Frequent Headaches	__ Bite Adjusted	__ Cold Sores or Blisters
__ Implants	__ Ringing in Ears	__ Bridges	__ Dental Phobia
__ Root Canals	__ Trauma to Head	__ Crowns	__ 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
Apply fluoride at each checkup? ___ yes ___ no
Administer nitrous oxide to your child? ___ 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 __ %

Pre Med ___ yes ___ no

Registration Completed by _____ Date _____

Registration:
Referral _____
Medical _____
Recall _____
Insurance _____
Alternate Address?

Messages:

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 Cell and/or E-Mail procedure necessary to confirm your appointments:

Cell phone confirmation;
Cell phone number for Texting_____

E-Mail confirmation;
E-mail address_____

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.

X_____

(Patient Signature) (Date)