Dental
Art and Science
Richard H. Berman D.M.D.

PERSONAL INFORMATION

Last Name: _____ **First Name:** _____

Date of Birth: _____ **SSN:** _____

Marital Status: _____ **Referred by:** _____

CONTACT INFORMATION

Address: _____

City: _____

St: _____ **Zip:** _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

E-Mail: _____

DENTAL INSURANCE INFORMATION

Carrier: _____

Carrier Address: _____

Group Number: _____

ID Number: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Relationship to Subscriber: _____

HEALTH QUESTIONNAIRE

Name _____ Birth date _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time ..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? ..... Yes No
   If so explain? _____
3. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No
   If so when? _____
6. How often do you brush _____
   Brush is: Soft ☐ Medium ☐ Hard ☐
7. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blisters, lip/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

TEETH

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
If so, when _____		
Shifting in bite	Yes	No
Change in bite	Yes	No

8. Do you use the following?

Brush	Yes	No
Dental floss	Yes	No
Fluoride rinse	Yes	No
Other _____		

MEDICAL

1. Has there been any change in your general health within the past year ..... Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician ..... Yes No
   If so, what is the condition being treated _____
4. The name and address of my physician is _____
   _____
5. Have you had any serious illness within the past five (5) years ..... Yes No
   If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years ..... Yes No
   If so, what was the problem _____
7. Do you have or have you had any of the following diseases or problems

a. Rheumatic fever or rheumatic heart disease	Yes	No
b. Congenital heart disease	Yes	No
c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.)	Yes	No
1) Do you have pain in chest upon exertion	Yes	No
2) Are you ever short of breath after mild exercise	Yes	No
3) Do your ankles swell	Yes	No
4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep	Yes	No
d. Artificial or replacement valves	Yes	No
e. Pacemaker	Yes	No
f. Allergy	Yes	No
g. Sinus trouble	Yes	No
h. Asthma or hay fever	Yes	No
i. Hives or a skin rash	Yes	No
j. Fainting spells or seizures	Yes	No
k. Diabetes	Yes	No
1) Do you have to urinate (pass water) more than six times a day	Yes	No
2) Are you thirsty much of the time	Yes	No
3) Does your mouth frequently become dry	Yes	No

l. Hepatitis, jaundice or liver disease ..... Yes No
m. Arthritis or inflammatory rheumatism ..... Yes No
n. Artificial or replacement joints, prosthetic ..... Yes No
o. Digestive system—Ulcers or stomach disorders (colitis) ..... Yes No
p. Kidney trouble ..... Yes No
q. Tuberculosis ..... Yes No
r. Persistent cough or cough up blood ..... Yes No
s. Immune System disorders (including AIDS, HIV, ARC) ..... Yes No
t. Venereal disease ..... Yes No
u. Other _____

8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ..... Yes No
   a. Do you bruise easily ..... Yes No
   b. Have you ever required a blood transfusion ..... Yes No
      If so, explain the circumstances & when _____
9. Have you ever tested positive for the AIDS virus? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? ..... Yes No
12. Are you taking any of the following:
   a. Antibiotics or sulfa drugs ..... Yes No
   b. Anticoagulants (blood thinners) ..... Yes No
   c. Medicine for high blood pressure ..... Yes No
   d. Cortisone (steroids) ..... Yes No
   e. Tranquilizers ..... Yes No
   f. Antihistamines ..... Yes No
   g. Aspirin ..... Yes No
   h. Insulin, tolbutamide (Orinase) or similar drug for diabetes ..... Yes No
   i. Digitalis or drugs for heart trouble ..... Yes No
   j. Nitroglycerin ..... Yes No
   k. Other medications ..... Yes No
   l. If "Yes" to any of the above, state drug name, dosage and frequency _____
13. Are you allergic or have you reacted adversely to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or other antibiotics ..... Yes No
   c. Sulfa drugs ..... Yes No
   d. Barbiturates, sedatives, or sleeping pills ..... Yes No
   e. Aspirin ..... Yes No
   f. Iodine ..... Yes No
   g. Codeine or other narcotics ..... Yes No
   h. Other _____
14. Do you use any tobacco products ..... Yes No
   If so, how much per day and what _____
15. Do you use any alcohol products ..... Yes No
   If so, how much per day/week/month and what _____
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) ..... Yes No
   If so, how much per day and what _____
17. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
   If so, explain _____
   _____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation ..... Yes No
19. Are you wearing contact lenses ..... Yes No
20. Are you experiencing stress or pressure in your work or at home ..... Yes No

WOMEN

20. Are you pregnant ..... Yes No
21. Do you have PMS or problems associated with your menstrual period ..... Yes No
22. Are you taking birth control or hormone therapy ..... Yes No

Remarks:

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 change in my medication, I will inform the dentist at the next appointment.

_____ _____

Signature of Patient Date Signature of Dentist Date

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Art and Science
Richard H. Berman D.M.D.

We welcome you to our office and want to provide you with the best care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

INFORMED DENTAL CONSENT

Dental procedures are not to be taken for granted as routine or without the risk of complications. As with all medical treatment to ones body, there are no guarantees that the results will be exactly as planned. Complications in dentistry are very low but they do exist.

Even minor procedures like a simple 'filling' can lead to major complications that can't be foreseen. For example, a local anesthetic injection could lead to an allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death.

Granted these are fairly uncommon occurrences but individuals who are contemplating treatment should be aware of this prior to consenting.

Whenever drilling is involved, even a simple cavity can lead to nerve problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatment.

The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems.

Initials _____ Date _____

SCHEDULING/CANCELLING APPOINTMENTS

When you make an appointment we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We reserve right to charge for any appointment(s) broken without a 24 hours notice. The charge will be $50.00 for every thirty (30) minutes of appointment time.

Initials _____ Date _____

I have read and understand Dr. Richard H. Berman's Informed Dental Consent, Financial Policy and Scheduling Policy.

_____ _____

Signature of Patient / Parent or Guardian (if minor) **Date**

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richberman@DentalArtandScience.com

Dr. Richard H. Berman
34 Berkley Road
Suite 100
Devon, PA 19333
610-687-6950
Fax 610-687-6955
email@dentalartandscience.com

REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record, including all x-rays, written treatment records and charting. The undersigned and listed patient hereby requests the transfer of said records and, we hereby, request that you release the following patient's records.

Patient's name:

Date of Birth:

Address:

_____ _____
Patient or Guardian Date

The undersigned acknowledges receipt that they are lawfully authorized to receive said records.

_____ _____
Richard H. Berman, D.M.D. Date

We thank you in advance for help and cooperation in this matter.

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FINANCIAL POLICY

All procedures involving lab work will require 50% down payment, the remaining 50% balance will be due as treatment progresses.
If you are having extensive treatment over a period of time, we request payments during the course of treatment.

Patients WITH Insurance Coverage:

We do not belong to any insurance network, but we will gladly submit your claims to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for the payments of your account. We can request a pre-estimate of benefits from your insurance carrier at your request.

Patients WITHOUT Insurance Coverage:

Patients without insurance coverage are required to pay for services as rendered. We accept Cash, Checks, MasterCard, Visa, American Express, Discover, or Debit/ATM cards.

Payment Options

Please check below, the option(s) most convenient for you to settle, in full, the day of treatment:

☐ **Cash/Check**_____**Exp:**_____**CVV:**_____

☐ **American Express** _____**Exp:**_____**CVV:**_____

☐ **Visa** _____**Exp:**_____**CVV:**_____

☐ **Master Card**_____**Exp:**_____**CVV:**_____

☐ **Discover**_____**Exp:**_____**CVV:**_____

Initials _____ **Date** _____

I have read and understand Dr. Richard H. Berman's Financial Policy.

_____ _____

Signature of Patient / Parent or Guardian (if minor) **Date**

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