# Mark D. Berard, DDS

Mark D. Berard, DDS
E 32nd Street, Suite 10,
Holland, MI 49423
616-392-2853
mberhomi.bptemp21.com

## New Patient Form

| Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you. | Date: / / | Patient #: |
|---|---|---|

## Patient Information

| Title: | First Name: | Middle Name: | Last Name: | I prefer to be called: |
|---|---|---|---|---|
| | | | | |

| Sex: | Age: | Date of Birth (mm/dd/yyyy): / / | Marital Status: | Social Security #: - - |
|---|---|---|---|---|
| | | | | |

| Home Phone: - - | Work Phone: - - | Cell Phone: - - | E-mail Address: |
|---|---|---|---|
| | | | |

| Home Address: | City: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

| Employment: | Employer's Name: | Employer's Phone: - - |
|---|---|---|
| | | |

| Employer's Address: | City: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

| Student Status: | School Name (if a full-time student): | Grade: |
|---|---|---|
| | | |

| Best places and times to contact you: | Send appointment reminders via: ❑ Text Message ❑ Email ❑ Mail |
|---|---|
| | |

Please tell us where you heard about us (check all that apply):

❑ Friend or Relative (name): ❑ Newspaper Ad ❑ Radio Ad ❑ TV Ad
❑ Ad in Mail ❑ Saw our Office ❑ Insurance Company ❑ Our Website
❑ Search Engine (Google, etc.) ❑ Other Website:
❑ Other:

Was our website a factor in your decision to visit our practice? ❍ Yes ❍ No

| Name of Spouse (or Parent, if a minor): | Spouse/Parent's Employer: | Spouse/Parent Work Phone: - - | Spouse/Parent Cell Phone: - - |
|---|---|---|---|
| | | | |

## Emergency Contact

*This should be the nearest relative who does not live with the patient.*

| Title: | First Name: | Last Name: | Relationship to Patient: |
|---|---|---|---|
| | | | |

| Home Phone: - - | Work Phone: - - | Cell Phone: - - | E-mail Address: |
|---|---|---|---|
| | | | |

| Emergency_Contact Address: | City: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

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## Person Responsible for Account

| Title: | First Name: | Middle Name: | Last Name: | Relationship to Patient: |
|---|---|---|---|---|
| | | | | |

| Date of Birth (mm/dd/yyyy): | Social Security #: | Driver's Licence State & #: | Holder of Dental Insurance for Patient: |
|---|---|---|---|
| / / | - - | | |

| Home Phone: | Work Phone: | Cell Phone: | E-mail Address: |
|---|---|---|---|
| - - | - - | - - | |

| Billing Address: | City: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

| Employment: | Employer's Name: | Employer's Phone: |
|---|---|---|
| | | - - |

| Employer's Address: | City: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

## Insurance Information

### Primary Insurance

| Insurance Holder's Name: | Date of Birth (mm/dd/yyyy): | Relationship to Patient: | Employer: |
|---|---|---|---|
| | / / | | |

| Member ID: | Group ID: | Insurance Company Name: | Insurance Company Phone: |
|---|---|---|---|
| | | | - - |

| Insured's SSN: | Insurance Company's Address: | City: | State: | ZIP Code: |
|---|---|---|---|---|
| | | | | |

### Secondary Insurance

| Insurance Holder's Name: | Date of Birth (mm/dd/yyyy): | Relationship to Patient: | Employer: |
|---|---|---|---|
| | / / | | |

| Member ID: | Group ID: | Insurance Company Name: | Insurance Company Phone: |
|---|---|---|---|
| | | | - - |

| Insured's SSN: | Insurance Company's Address: | City: | State: | ZIP Code: |
|---|---|---|---|---|
| | | | | |

### Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Mark D. Berard, DDS to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Mark D. Berard, DDS. I permit a copy of this authorization to be used in place of the original. I give Mark D. Berard, DDS, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

| Signature (Type your name to sign electronically, or print and sign): | Date (mm/dd/yyyy): |
|---|---|
| | / / |

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## Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

| Signature (Type your name to sign electronically, or print and sign): | Date (mm/dd/yyyy): / / |
|---|---|

## Dental History

### Previous Dentist

| Dentist Name: | Dental Practice Name: | Phone: - - |
|---|---|---|

| Address: | City: | State: | ZIP Code: |
|---|---|---|---|

| What did you like about your last dentist? | What caused you to leave your last dentist? |
|---|---|

### Last Dental Visit

| Last Dental Visit (m/y): / | What were you treated for? | Treatment complete? ❍Yes ❍No |
|---|---|---|

| What was done at your last dental visit? | Last X-Rays: / | Last Full-Mouth X-Rays: / | Last Cleaning: / |
|---|---|---|---|

### Dental Hygiene

| How often do you visit a dentist? | Do you brush your teeth? If yes, how often? | Do you floss? If yes, how often? |
|---|---|---|
| Regularly | Yes After every meal | Yes After every meal |

| Please list other dental hygiene aids (Interplak, toothpicks, etc.) that you use: | Are you interested in regular hygiene cleanings? |
|---|---|
| | Yes |

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## Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:

Yes

What is the main reason for your visit today?

❏ Tooth Pain ❏ Check-up ❏ Cleaning ❏ Whitening ❏ Cosmetic Dentistry
❏ Sedation Dentistry ❏ Restorative Dentistry ❏ Other:

What would you like to learn more about?

❏ Whitening ❏ Cosmetic Dentistry ❏ Sedation Dentistry ❏ Implants ❏ Bridges ❏ Veneers
❏ Dentures ❏ Other:

## Dental Concerns

*Check all that apply.*

### Teeth

| | | | |
|---|---|---|---|
| ❏ Broken or chipped | ❏ Loose/missing filling | ❏ Missing teeth | ❏ Sensitive to sweets |
| ❏ Crooked | ❏ Loose teeth | ❏ Mouth sores | ❏ Blisters on lips/mouth |
| ❏ Decay | ❏ Tooth pain | ❏ Sensitive to cold | ❏ Orthodontic treatment |
| ❏ Difficulty chewing | ❏ Food trap areas | ❏ Sensitive to heat | ❏ Bad taste in mouth |
| ❏ Discolored | ❏ Grinding or clenching | ❏ Sensitive when biting | |

### Gums

| | | | |
|---|---|---|---|
| ❏ Bad breath | ❏ Abscessed | ❏ Sore | ❏ Receding |
| ❏ Red (discolored) | ❏ Bleeding | ❏ Swollen | ❏ Periodontal treatment |

### Facial/Jaw Pain

| | | | |
|---|---|---|---|
| ❏ Frequent headaches | ❏ Pain in temples | ❏ Jaw injury | ❏ Pain around ear |
| ❏ Avoid certain foods | ❏ Jaw locks open/closed | ❏ Head injury | |
| ❏ Popping/clicking | ❏ Pain in jaw | ❏ Neck injury | |

### Other Concerns

| | | |
|---|---|---|
| ❏ Smoking/dipping | ❏ Orthodontic treatment | ❏ Snoring |
| ❏ Biting cheeks or lip | ❏ Burning tongue | ❏ Teeth straightening |
| ❏ Popping/clicking | ❏ Tooth replacement | ❏ Retainer |
| ❏ TMJ | ❏ Fractured tooth syndrome | ❏ Dry mouth |
| ❏ Tooth-colored fillings | ❏ CPAP | ❏ Wisdom teeth extraction |
| ❏ Wisdom teeth | ❏ Implants - Tooth #: | ❏ Cosmetics |
| ❏ Nail-biting | ❏ Jaw locks open/closed | ❏ Smile makeover |
| ❏ Sleep apnea | ❏ Stain | ❏ Dental phobias |
| ❏ Limited orthodontics | ❏ Chew on one side | |

Does food tend to get caught between your teeth? If yes, where?

Yes

Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) with your teeth? If yes, what?

Yes

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## Have you ever had:

*Check all that apply.*

❏ Orthodontic treatment ❏ Periodontal treatment ❏ Your bite adjusted
❏ Oral surgery ❏ Your teeth ground ❏ A bite plate or mouth guard

❏ Any canker sores or cold sores on your lips, tongue, gums, or body
❏ A serious injury to the mouth or head? If yes, please describe including cause:

## Miscellaneous

What do you like most about your teeth/smile?

Is there anything you don't like about your teeth/smile?

Is there anything you'd like to change about your teeth/smile?

What are your long-term dental goals? How would you like your teeth to feel and look?

What are your short-term dental goals?

Do you have any upcoming event or circumstances (such as weddings, major surgeries, etc.) we should/need to know about? If yes, what and when?

Yes

Is there anything else you feel we should know?

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## HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders

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of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 10, 2016, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S.

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Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

## HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Mark D. Berard, DDS to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

| Signature (Type your name to sign electronically, or print and sign): | Date (mm/dd/yyyy): / / |
|---|---|
| If signing on behalf of someone, explain your relationship to the patient: | |

## For Office Use Only

*Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.*

| The following circumstances prohibited the patient from signing the consent form: | | | |
|---|---|---|---|
| Describe your good faith effort to obtain the individual's signature on this form: | | | |
| Office Personnel Signature: | Office Personnel Name: | Office Personnel Title: | Date: / / |

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## Medical History Form

**If you have not already, please click here to open a new window where you will be redirected to our Medical History Form.**
**This form must be filled out and brought to the office separately. After the new window opens with the Medical History Form, make sure to return here and click "Finish Form Submission" below!**