Hi Berry, Inc.

Date: _____ **Dr. Gloria Berry-Holly**

Patient Information

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Email Address: _____ SS# _____ DL#_____

Birth date: _____ Sex M F Are you a full time student? Y or N where? _____

Emergency Contact: _____ Phone # (_____) _____-_____

How did you hear about our office? _____

Responsible Party Information

Name: _____
Last First Middle

Address: _____
Street City State Zip

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Birthdate: _____ Sex M F SS# _____

Insurance Information

Primary Insurance:

Insured Name: _____ Insured SS/ID#: _____ Date of Birth: _____

Employer: _____ Insurance Company: _____ Group # _____

Claims Address: _____ Phone #(_____) _____-_____

Secondary Insurance:

Insured Name: _____ Insured SS/ID#: _____ Date of Birth: _____

Employer: _____ Insurance Company: _____ Group # _____

Claims Address: _____ Phone #(_____) _____-_____

Dental Information

Do your gums bleed when you brush? Y N
Are your teeth sensitive to hot or cold? Y N
Do you grind or clench your teeth? Y N
Do you have a fear of dental work? Y N

Date of last dental visit: _____ What was done at that time? _____

Former Dentist Name: _____ City: _____

How would you describe your current dental problem? _____

_____

How do you feel about the appearance of your teeth? _____

_____

Patient Name: _____

Date: _____

Hi Berry, Inc.
Dr. Gloria Berry-Holly
Medical History

A. Are you having tooth or gum pain at this time? ❑YES ❑NO
B. Have you been a patient in hospital in the last two years? ❑YES ❑NO
C. Are you now taking any drugs or medications? ❑YES ❑NO If yes, please list: _____
D. Have you taken any medications or drugs in the last two years? ❑YES ❑NO
E. Are you taking any herbal supplements or over the counter medications? (i.e. aspirin?) ❑YES ❑NO
F. Have you been under the care of a medical doctor during the last two years? ❑YES ❑NO
Physicians Name: _____ Phone # _____
G. Are you sensitive or have had an allergic reaction to:

1. Local anesthetics
2. Barbiturates, sedatives, or sleeping pills
3. Codeine or other narcotics
4. Penicillin or other antibiotics
5. Aspirin
6. Other _____
7. Sulfa drugs
8. Iodine

H. Indicate which of the following you have had or have at the present.

1. Heart Failure ..... YES NO	*18. Artificial Joints (hip, knee, etc.) ..... YES NO*	*35. Hepatitis A ..... YES NO*
2. Heart Disease or Attack ..... YES NO	*19. Kidney Trouble ..... YES NO*	*36. Hepatitis B ..... YES NO*
3. Angina Pectoris ..... YES NO	*20. Ulcers ..... YES NO*	*37. Venereal Disease ..... YES NO*
4. Congenital Heart Disease ..... YES NO	*21. Diabetes ..... YES NO*	*38. A.I.D.S. ..... YES NO*
5. Heart Murmur ..... YES NO	*22. Thyroid Problems ..... YES NO*	*39. HIV Positive ..... YES NO*
6. High Blood Pressure ..... YES NO	*23. Glaucoma ..... YES NO*	*40. Cold Sores/Fever Blisters ..... YES NO*
7. Arteriosclerosis ..... YES NO	*24. Cancer ..... YES NO*	*41. Blood Transfusion ..... YES NO*
8. Mitral Valve Prolapse ..... YES NO	*25. Emphysema ..... YES NO*	*42. Hemophilia ..... YES NO*
9. Artificial Heart Valve ..... YES NO	*26. Chronic Cough ..... YES NO*	*43. Anemia ..... YES NO*
10. Heart Pacemaker ..... YES NO	*27. Tuberculosis ..... YES NO*	*44. Sickle Cell Disease ..... YES NO*
11. Heart Surgery ..... YES NO	*28. Asthma ..... YES NO*	*45. Bruise Easily ..... YES NO*
12. Rheumatic Fever ..... YES NO	*29. Hay Fever ..... YES NO*	*46. Liver Disease ..... YES NO*
13. Arthritis ..... YES NO	*30. Allergies or Hives ..... YES NO*	*47. Yellow Jaundice ..... YES NO*
14. Rheumatism ..... YES NO	*31. Sinus Trouble ..... YES NO*	*48. Fainting or Dizziness ..... YES NO*
15. Cortisone Medicine ..... YES NO	*32. Radiation Therapy ..... YES NO*	*49. Tumors ..... YES NO*
16. Drug Addiction ..... YES NO	*33. Chemotherapy ..... YES NO*	*50. Stroke ..... YES NO*
17. Developmentally Disabled ..... YES NO	*34. Allergy to Metal or Jewelry ..... YES NO*	*51. Allergy to Latex ..... YES NO*
		52. Epilepsy or seizures ..... YES NO

I. When you walk up the stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are overtired? ❑YES ❑NO
J. Are you on a special diet? ❑YES ❑NO
K. Do your ankles swell during the day? ❑YES ❑NO
L. Do you use more than two pillows to sleep? ❑YES ❑NO
M. Do you ever wake up from sleep and feel short of breath? ❑YES ❑NO
N. Have you lost or gained more than ten pounds in the past year? ❑YES ❑NO
O. Do you use tobacco products? ❑YES ❑NO
P. Do you have or have you had any disease, condition, or problem not listed? ❑YES ❑NO

FOR WOMEN ONLY:
Are you pregnant? ❑YES ❑NO, what month? ___ Are you nursing? ❑YES ❑NO Are you taking birth control pills? ❑YES ❑NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and the best to my knowledge. I have made the office aware of any past or present medical conditions or medications not listed on this form.

Patient Signature: _____ **Date:** _____

Hi Berry, Inc.
Dr. Gloria Berry-Holly, D.D.S.
Financial Policies and Procedures

Insurance: As a courtesy, we will assist you in filing your insurance. We are not party to your insurance as it is an agreement between you, your employer and your insurance company. You are responsible for any co payments, co insurance amounts or deductibles at the time of service, unless prior arrangements have been made. Any amount not covered by your insurance company, will be automatically billed to you.

Medicaid: Our office accepts Medicaid. All co payments are due at the time of service. Payments for services performed not covered by Medicaid are due at the time of service, unless prior arrangements have been made.

Payments/Financing: We accept MasterCard, VISA, Discover, cash, check and money order. We offer financing options through CareCredit.
If you are interested in the convenience of placing your remaining balance after insurance on a major credit card, authorize below:

□VISA □MASTERCARD □*DISCOVER*

Card #: _____ *Exp Date:* _____

Signature: _____ *Date:* _____

Returned Checks: There is a $25 fee for all returned checks.

Cancellation Policy: If you are unable to keep your scheduled appointment, we ask that you kindly provide us with at least 24 hours notice. We reserve the right to charge for missed or broken appointments that were not cancelled within 24 hours of the appointment time. If you have an appointment scheduled on a Monday, the appointment must be cancelled by Thursday, the week before. Our office will give reminder calls and emails to confirm scheduled appointments as a courtesy.

Consent:

1. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnostic aid deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
2. I understand that all responsibility for payment dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a finance charge may be added to my account, in addition to any collection charges.
3. I understand that it is my responsibility to advise your office of any changes in the information obtained in this form.

_____ _____

Signature of Patient/ Legal Guardian ***Date***

Hi Berry, Inc.
Dr. Gloria Berry-Holly

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____ have received/reviewed a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

**Please note, a copy of our Notice of Privacy Practices is posted in the office. To obtain a copy of our Notice of Privacy Practices, please see the administrative staff.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).