Richard M. Berg, DDS

FAMILY DENTISTRY

Warwick Center
54 Copperfield Circle
Lititz, PA 17543

Tel. 717.627.3113
Fax 717.627.0723

drberg@drberg.net
www.drberg.net

Welcome to our office! We are pleased that you are interested in becoming a part of Dr. Berg's family of patients. We look forward to your visit in our office and strive to provide you with modern, thorough dental treatment in a pleasant, gentle and efficient manner. We believe that you will find a visit to Dr. Berg's office to be a progressive experience!

Our main goal, wherever possible, is the retention of healthy natural teeth. To accomplish this goal, we need your cooperation. We hope to achieve a clear mutual understanding by keeping you well informed at all times. With this in mind, here is a description of what to expect on your first visit to our office:

Your first visit will include a brief introduction to our office, a review of your health history, and an accurate diagnosis of the condition of your teeth, gums and mouth. Dental needs will be assessed at this visit and a suitable plan of treatment will be discussed with you. In order to diagnose your dental condition, x-rays will be required. Occasionally other diagnostic aids such as study models will be required.

Personal comfort, appearance, and the maintenance of dental health are of primary importance to us. If treatment is indicated, we will try to restore optimum dental health in as few well-planned appointments as necessary. We generally recommend that corrective treatment begin as soon as possible.

Our policy is that x-rays be taken when necessary. First exams will require either a full set of x-rays or a panoramic x-ray and bitewing x-rays, unless current x-rays have been forwarded to our office in advance.

Parents or guardians of minors **must** accompany the child into the office and remain available to answer any questions about the child's medical/dental history and consent for treatment.

Continued on other side

As a service to our patients, our office submits insurance claims after treatment is provided. If you have dental insurance, we ask you review your entire insurance plan document before your first visit. Depending on your insurance contract, collection options for insured patients include paying the entire balance due on the day of service and receiving reimbursement from your insurance, or leaving a credit card number in our secure system to cover and balance remaining after insurance payment is received by our office. If applicable, please bring a current insurance card with you to your first appointment.

For your convenience, we accept cash, check, debit, CareCredit, MasterCard, Visa, Discover and American Express. On your first visit, please come prepared to cover the entire visit on the day of service.

We have enclosed a patient information form, medical history, dental questionnaire and our Notice of HIPAA Privacy Practice. Please take a few minutes to complete and sign these forms, and bring them to your first appointment. Please plan to arrive at least ten minutes prior to your scheduled appointment.

Should you have any questions about our office, services, or policies, please communicate with us. We welcome your telephone call at (717) 627-3113 or fax at (717) 627-0723. Also feel free to read our web page: www.drberg.net or email us from that link or to drberg@drberg.net. In the case of an emergency, Dr. Berg may be reached by cell phone (717) 575-3494. We look forward to a pleasant and relaxed visit with you.

Sincerely,

Richard M. Berg DDS & Team

Richard M. Berg, DDS, FAGD
54 Copperfield Circle
Lititz, PA 17543
(717) 627-3113

Date: _____ Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Soc. Sec. # ___-___-_____ Birthdate ___/___/___ Home Ph. # ( ) _____ Cell Ph. # ( ) _____

Email: _____ Sex: M F If patient is a minor, parent's/guardian's name_____

Name of nearest relative not living with you: _____ Relationship: _____

Complete Address _____ Ph. # ( ) _____

Emergency Contact _____ Ph. # ( ) _____

Responsible Party Information

Name_____
Last First Middle Marital Status

Soc. Sec.# ___-___-_____ Birthdate _____/_____/_____ Relationship to Patient _____

Mailing Address _____ How long at this address? _____
Street City State Zip Code

Home Ph. # ( ) _____ Work Ph. # ( ) _____ Email Address: _____

Previous Address (if less than 3 years) _____

Employer_____ Occupation _____ No. Years Employed_____

Employer Address_____

Spouse's Name _____ Birthdate ___/___/___ Phone # ( ) _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. #_____

Place of Employment_____ Ph. # ( ) _____

Insurance Company _____ Group # _____

I.D. #_____

Insurance Co. Address _____ Ph. # ( ) _____

Consent

1. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. I also authorize doctor to perform all recommended treatment mutually agreed upon and to use the appropriate medication and/or therapy indicated for such treatment.
2. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due at the time services are rendered unless prior arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a $4.00 monthly late charge may be added to my account in addition to any collection charges.
3. I understand that credit bureau reports may be obtained and authorize this office to obtain same, at their discretion.
4. I understand that it is my responsibility to advise this office of any changes in the information obtained on this form.
5. I understand that the information on this form will be held in strict confidence.
6. I authorize the release of personal/dental information to any referral Dr. and/or insurance company. This includes (but is not limited to) treatment plans, radiographs, periodontal information, ADA codes and charges.

_____ _____ _____
Signature of Patient or Responsible Party Print Patient Name Date

Richard M. Berg, D.D.S., P. C.

www.drberg.net
54 Copperfield Circle • Lititz, PA 17543-9483

drberg@drberg.net
(717)627-3113

Medical History

Patient Name: _____ (Last) _____ (First) ____ (M)

_____ (Preferred Name)

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med - Amox
- ☐ Allergy - Amoxicill
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ HIV
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Respiratory Problems
- ☐ Sleep Apnea
- ☐ Take Bisphosphonate
- ☐ Tuberculosis
- ☐ *Pre-Med - Clind
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Allergy - Sulfa
- ☐ Asthma
- ☐ Dizziness
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Taking Blood Thinner
- ☐ Tumors
- ☐ *Pre-Med - Other
- ☐ Allergy - Codeine
- ☐ Allergy - Metal
- ☐ Anemia
- ☐ Blood Disease
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ MVP
- ☐ Previously smoked
- ☐ Rheumatism
- ☐ Stroke
- ☐ Thyroid
- ☐ Ulcers
- ☐ Allergies
- ☐ Allergy - Dent Anes
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Cancer
- ☐ Ever Hospitalized
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Sulfa
- ☐ Tobacco Use
- ☐ Vit K

FEMALES ONLY:

☐ Taking contraceptives ☐ Using Hormone Replacement Therapy ☐ Pregnant or planning pregnancy

☐ Nursing

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____

_____

Do you have any allergies not listed above (including allergies to medications)? If yes, please list below: ○ Yes ○ No

*

ALLERGIES:

_____

_____

Have you had an orthopedic total joint replacement (hip,knee,elbow,finger), if so, please describe below. Please include any complications from procedure:

_____

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please list medication below: * ○ Yes ○ No

PRE MED:

Name of your physician:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Are you taking any medications (prescription and non-prescription) including regular doses of aspirin or birth control pills? If yes, please list all medications below. ○ Yes ○ No

Please list any medications you are currently taking, one medication per line:

Name and phone number/location of your preferred pharmacy: *

☐ *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Response Date: _____

RICHARD M. BERG, DDS
General Dentistry
Warwick Center
54 Copperfield Circle
Lititz, PA 17543
(717) 627-3113

Dental Questionnaire

Our most important goal is to meet the needs of our patients who have entrusted their dental care to us. We are here to serve you. Kindly help us know you, your needs and expectations by sincerely answering the following questions.

What is the main reason for contacting our office?_____

List two things (or more) most important to you, that you look for in a dental office.

_____

When was your last dental visit? _____ **What was done?** _____

Are you interested in: (Please check all that apply)

____ **Tooth Whitening** ____ **Replacing missing teeth** ____ **Replacing silver fillings**
____ **Improving smile appearance** ____ **Being able to chew better**

Do you fear dental work? (Circle one) Low **0 1 2 3 4 5 6 7 8 9 10** High

Do you have a specific dental concern? _____

If you were made aware of a dental condition that might lead to more severe problems, you would likely:

a) **Take necessary precautions in advance to prevent future problems**
b) **Take your chances to see if problems develop and correct them at that time**

Are you presently in pain / discomfort? (Y / N) **If Yes, please explain:**_____

_____

Are your teeth sensitive to: ____Hot ____Cold ____Both? **If Yes, where?** _____

Are your teeth sensitive to pressure or biting? (Y / N) **If Yes, where?** _____

Are your teeth sensitive to sweets? (Y / N) **If Yes, where?** _____

Have you ever had an injury to your jaw/ face? (Y / N) **If Yes, where?** _____

Do your gums bleed when you floss or brush? (Y / N) Do you have a history of gum disease? (Y / N)

Have you previously had any of the following done? (Please check all that apply)

____ **Orthodontics (braces)** ____ **Crowns/Bridges** ____ **Root Canals**
____ **Bleaching** ____ **Wisdom teeth extracted**

Are there any concerns or questions you may have that are not addressed in the above questions?

Thank you for helping us serve you!
Dr. Berg and Staff

Notice of Privacy Practices

Richard M. Berg, DDS
54 Copperfield Circle, Suite 105
Lititz, PA 17543
Phone: 717-627-3113
Effective Date: April 14, 2003
Revised Date: June 21, 2019

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. **Ask for an electronic or paper copy of your health record**
   - You can ask to see or get an electronic or paper copy of your health record and other health information we have about you. Ask us how to do this.
   - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
2. **Ask us to correct your health record**
   - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
   - We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. **Request confidential communications**
   - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
   - We will say "yes" to all reasonable requests.
4. **Ask us to limit what we use or share**
   - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
   - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
5. **Get a list of those with whom we've shared information**
   - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
   - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
6. **Get a copy of this Privacy Notice**
   - You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.
7. **Choose someone to act for you**
   - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
   - We will make sure the person has this authority and can act for you before we take any action.
8. **File a complaint if you feel your rights are violated**
   - You can complain if you feel we have violated your rights by contacting us using the information at the end of this document.
   - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting: www.hhs.gov/ocr/privacy/hippa/complaints/.
   - We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

1. **In the situations below, you have both the right and choice to tell us to:**
   - Share information with your family, close friends, or others involved in your care
   - Share information in a disaster relief situation
   - Include your information in a hospital directory

   If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
2. **In the situations below, we never share your information unless you give us written permission:**
   - Marketing purposes
   - Sale of your information
   - Most sharing of psychotherapy notes
3. **In the case of fundraising:**
   - We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

1. **Treat you**
   - We can use your health information and share it with other professionals who are treating you.

   Example: A doctor treating you for an injury asks another doctor about your overall health condition.
2. **Run our organization**
   - We can use and share your health information to run our practice, improve your care, and contact you when necessary.

   Example: We use health information about you to manage your treatment and services.
3. **Bill for your services**
   - We can use and share your health information to bill and get payment from health plans or other entities.

   Example: We give information about you to your health insurance plan so it will pay for your services.

How Else Can We Use or Share Your Health Information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

1. We can share health information about you for **certain situations** such as:
   - Preventing disease
   - Helping with product recalls
   - Reporting adverse reactions to medications
   - Reporting suspected abuse, neglect, or domestic violence
   - Preventing or reducing a serious threat to anyone's health or safety
2. **Do research**

   We can use or share your information for health research.
3. **Comply with the law**

   We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
4. We can share health information about you with **organ procurement organizations.**
5. We can share health information with a **coroner, medical examiner, or funeral director** when an individual dies.
6. Address **workers' compensation, law enforcement, and other government requests.**

   We can use or share health information about you:
   - For workers' compensation claims
   - For law enforcement purposes or with a law enforcement official
   - With health oversight agencies for activities authorized by law
   - For special government functions such as military, national security, and presidential protective services
7. We can share health information about you in response to a **court or administrative order, or in response to a subpoena.**

State-Specific Disclosure Restrictions

Pennsylvania Health Privacy Law

PA: We will not share any HIV-related, mental health, or substance abuse treatment records without your written permission, except as required by law. MD: We will only share medical records as required by the Maryland privacy laws.

Our Responsibilities

1. We are required by law to maintain the privacy and security of your protected health information.
2. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
3. We must follow the duties and privacy practices described in this Notice and give you a copy of it.
4. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our web site.

Complaints

If you believe your privacy rights have been violated, contact our Practice Privacy Officer at:
Telephone Number: 717-627-3113
Email address: drberg@drberg.net

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I have been given a copy of Richard M. Berg, DDS *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that the Practice has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative *Date*

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

Completed by:

_____ _____
Signature of Practice Representative *Date*

_____
Print Name and Title

File Original in Patient's Health Care Record

Electronic Communications Patient Consent Form

Patient Name: _____ Date of Birth: _____

Richard M. Berg, DDS cannot guarantee, but will use reasonable means to maintain the security and confidentiality of electronic communications such as email or text messages. We take appropriate precautions when transmitting electronically to avoid unintentional disclosures, such as verifying your e-mail address or text number for accuracy before sending. The Practice is not liable, however, for improper disclosure of confidential information that is not caused by our intentional misconduct.

The Risks of Using Electronic Communications

Transmitting patient information electronically can be risky. Please consider the following possibilities before agreeing to communicate with us in this way. For example, messages can be intercepted, viewed, circulated, altered, forwarded, stored or used without authorization or detection. In addition, messages may be misaddressed, read by employers and online service providers, easily falsified, retained after deletion, used to introduce viruses, or used as evidence in court.

Still Want To Use Electronic Communications?

If you want to use email, texting, etc. to communicate with us, we have some final instructions:

- We cannot guarantee your communications will be read promptly, so please do not use these methods for urgent matters.
- Be sure to follow-up with us by phone if you are expecting a return response from us and do not receive one within 2 business days.
- Please notify us promptly if your email address, text number, etc. has changed.
- Be aware that most electronic communications from patients become a part of their health record.
- Do not use these methods to share sensitive medical information, such as communications about AIDS/HIV or mental health conditions, sexually transmitted diseases or substance abuse.

I understand the risks associated with electronic communications of personal health information, and give my consent for the practice to communicate with me through:

___ Text Messaging, using this phone number: _____

___ Email, using this email address: _____

If I have any questions, I will contact the Practice Privacy Officer.

Patient Signature: _____ *Print Name:* _____

Personal Representative: _____ *Print Name:* _____

Date: _____

Distribution of Copies: Original to Patient's Health Care Record, Copy to Patient.

Patient Consent to Disclose Protected Health Information Form

Patient Name: _____ Date: _____

Date of Birth: _____ Telephone Number: _____

Address: _____

Although not a requirement under HIPAA, patients may authorize Richard M. Berg, DDS to discuss protected health information with certain individuals. Because there may be occasions when sharing personal health information is not in the best interest of the patient, the Practice is allowed to evaluate your request and make a decision on whether we can agree to the request.

I give Richard M. Berg, DDS permission to discuss my protected health information with the following person(s):

(Please print clearly.)

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

_____ _____
Signature of Patient or Personal Representative *Date*

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Health Care Power of Attorney)

Distribution of Copies: Original to Patient's Health Care Record, Copy to Patient.