

MEDICAL HEALTH HISTORY

Date _____

PATIENT INFORMATION

Prefix _____ First Name: _____ M.I.: _____ Last name: _____ Sex: _____
 Birth Date: ____/____/____ Age: _____ Soc. Security #: _____
 Street: _____ Apt: _____ City: _____ State: _____ Zip: _____
 Home Tel.: _____ Cell: _____ E-mail: _____
 Referred By: _____ Dentist Name: _____
 Employer: _____ Bus. Tel.: _____ Occupation: _____ # yrs employed: _____
 In case of emergency, please contact: _____ Tel.: _____

SPOUSE OR OTHER GUARANTOR INFORMATION

Name: _____ Relation: _____ S.S. #: _____ Birth Date: ____/____/____
 Street (if different than above): _____ Apt: _____ City: _____
 State: _____ Zip: _____ Tel.: _____ Employer: _____ Bus. Tel.: _____

DENTAL INFORMATION

Reason for today's visit: _____ Are you in pain?: Yes No For how long?: _____

Please select any of the following problems:

- Toothache Heat sensitive
- Facial swelling Cold sensitive
- Lumps in mouth Biting sensitive
- Sweet sensitive Pain wakes me at night

MEDICAL HISTORY

Are you in good health? Yes No Height _____ Weight _____

Are you under the care of a physician? Yes No

Do you take antibiotic prophylaxis prior to dental treatment? (ex. Knee replacement, infective endocarditis) Yes No

Have you had any operations/been hospitalized in the last 5 years? Yes No

If yes, what for?: _____

Please list all medications that you are currently taking (including natural, herbal or homeopathic):

Medication	Dosage/Frequency
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had an allergic reaction to or are allergic to the following? Please list any other allergies in "other":

Y N

Penicillin/amoxicillin

Benzodiazepines/ sedatives

Soy

Sulfa Drugs

Y N

Codeine/ narcotics

Aspirin

Eggs/ yolk

Local anesthesia (numbing meds)

Y N

Latex

other _____

PLEASE READ AND SIGN BELOW:

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient signature (parent or guardian if minor): **X** _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain, and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted.
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office.
- File a statement of disagreement if your amendment is denied and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Elect to opt out of receiving further fundraising communications from the office/hospital
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Dr. Brooke Berson, 856.478.3100 5 Myers Drive, Suite 106, Mullica Hill, NJ 08062 in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Dr. Berson at 856.478.3100.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Dr. Berson. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is Jacob K. Javits Federal Building, 26 Federal Plaza, New York, NY 10278

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses 3

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____

Signature of patient (Parent of guardian)

Date

CONSENT FOR ENDODONTIC CONSULTATION AND TREATMENT

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment.

Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy, or when needed, endodontic surgery. The following discusses possible risks that can occur from endodontic treatment, and other treatment choices.

Risks: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections. These complications include swelling, sensitivity, bleeding, pain, infection, numbness and a tingling sensation on the lip, tongue, chin, gums, cheeks and teeth. These complications are transitory, but on infrequent occasions can be permanent. Other risks include: reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, trismus (restricted jaw opening), loosening of teeth, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

Risks more specific to endodontic therapy: The risks include the possibility of instruments broken within the root canals, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals and cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of teeth.

OTHER TREATMENT CHOICES: These may include no treatment, waiting for more definite development of symptoms, tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth and infection to other areas.

CONSENT: I, the undersigned, being the patient (parent or guardian of below minor patient) consent to performing of procedures decided upon to be necessary or advisable in the opinion of Dr. Brooke Berson. I further give my consent for Dr. Berson to take any radiographs, administer any medications, anesthetics, or drugs advisable as a component of the planned endodontic treatment. I also understand that upon completion of root canal therapy in this office, I shall return to my general dentist for a permanent restoration of the tooth involved. I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require treatment, surgery or even extraction.

Patient Name (Please Print)

Date

Patient Signature (Guardian if minor)

Witness Signature

OFFICE FINANCIAL CONSENT

- It is the intent of this office to assist you with your insurance benefit information and to keep down the cost of your care.
- We are not responsible for any information provided to us as a courtesy to you by your insurance company.
- It may be difficult to obtain reliable financial information from insurance companies regarding endodontic therapy. Contract allowances have many conditions for eligibility established by the insurance carrier not based on need for the services. These conditions for eligibility continually change and we are not always apprised of the changes.
- **Treatment fee and payment:** Payment is expected at the time of treatment. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. Any quotes that we receive are estimates only. All balances are due in full 90 days after treatment regardless of insurances intent to pay. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.**

Please read and sign the below statement in its entirety:

I understand that estimates of insurance benefits for services performed, both verbal and written, are ESTIMATES. I understand that this office attempts to obtain information about my benefits as a courtesy to me. I understand that my dental insurance carrier may pay less than the actual fee and/or estimate for services provided and I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize Dr. Berson to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

Patient Name (please print): _____ Date: _____

Patient Signature (or guardian): _____