



Patricia Berube, D.M.D., M.S., P.A.
Periodontics and Dental Implants, Exclusively
502 W. Oak St. Suite 102
Denton, TX 76201
www.dentonperio.com
(940) 384-7374

Welcome to our office. On your first visit, Dr. Berube will perform a thorough oral examination and give you a complete explanation of your condition and appropriate treatment options. Radiographs (x-rays) will be taken only if needed to allow the doctor to complete the diagnosis. You will experience little or no discomfort.

Dr. Berube will send a detailed report of her findings and recommendations, with radiographs (if taken), to your primary care dentist.

As discussed in our phone conversation, we will happily complete any needed insurance forms for you, although the full payment of your initial visit is expected at the time of service. If you have insurance, we will gladly re-imburse any over payment we receive or put a credit on your account to help with further treatment.

Please complete the health history, insurance information, and read and sign the enclosed office policy from the privacy of your home and bring them with you.

If you are required to take any type of medication, including antibiotics, before any dental appointments, please be sure to do so.

We are located on the northwest corner of Carroll Boulevard and W. Oak St. in Denton in a red brick office building. From I-35, please take Exit 465B (Fort Worth Drive/377) and go north. Stay straight on this road, as it turns into Carroll Blvd. Turn left onto W. Oak and we are on the immediate right. From Hwy 380, turn onto Carroll Blvd (across from the Kroger shopping center). Stay straight until you see W. Oak St. Take a right onto W. Oak and we are on the immediate right.

Our entire staff is looking forward to meeting you.

Sincerely,

Leigh Ann McCoy
Patient Care Coordinator

Patricia Berube, D.M.D., M.S.
Periodontics and Dental Implants, Exclusively

Name: _____ Maiden Name: _____ Hm phone: _____
Home address: _____ City: _____ Zip Code: _____
Cell phone: _____ Email address: _____ Wk phone: _____
Social Security #: _____ Driver's license #: _____ Date of Birth: _____
Patient's employer: _____ Employer's address: _____
Spouse's name: _____ Cell phone: _____ Social Security #: _____
Spouse's employer: _____ Employer address: _____ Wk Phone: _____
Nearest Relative not living with you: _____ Phone: _____
Nearest friend not living with you: _____ Phone: _____
Physician: _____ Phone: _____
Landlord: _____ Phone: _____
Emergency contact? _____ Phone: _____
Whom may we thank you for referring you to us? _____ Phone: _____
Who is responsible for this bill? _____

For your convenience, we offer the following methods of payment. Please check the option you prefer:
Cash ___ Personal check ___ Visa ___ MasterCard ___ American Express ___ Discover ___ CareCredit ___

Responsible Party Information (if different than patient information)

Person responsible for this account: _____ Relationship to patient: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____
E-mail address: _____ Best time and number to call: _____
Address: _____ City, State, Zip: _____
Is this person currently a patient in our office? Yes ___ No ___

Primary Dental Insurance Information

Name of insured: _____ Primary Insurance Company: _____
Insured's SS#: _____ Birthdate: _____ Employer Name: _____
Insurance Address _____
Insurance Phone# _____ Group# or Subscriber# _____

Secondary Dental Insurance Information (if applicable)

Name of insured: _____ Secondary Insurance Company _____
Insured's SS#: _____ Birthdate: _____ Employer Name: _____

I authorize Patricia Berube, D.M.D., M.S., P.A. to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize payment of dental benefits to Dr. Berube. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any dental services rendered. I have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature _____ Date _____

Parent (if minor) _____ Date _____

Patricia Berube, D.M.D., M.S.
Periodontics and Dental Implants, Exclusively

Patient Name: _____ Date: _____
Physician's name: _____ Office phone: _____ Date of last medical exam: _____

Please circle:

1) Are you under medical treatment now? Y N

If yes, for what _____

2) Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: _____ Y N

3) Do you use tobacco? Y N

If yes, what type, quantity per day, and how long? _____ Y N

4) Do you use any controlled substances? Y N

5) How many alcoholic beverages do you drink? _____

6) List any medications prescribed (including blood thinners, meds for osteoporosis and aspirin) and not prescribed (i.e. herbals, OTC, etc.) _____

7) Do you have or have you had any of the following?

High or Low Blood Pressure	Y	N	Hypoglycemia or low blood sugar	Y	N	Easy bruising/bleeding	Y	N
Heart Trouble, Heart Attack, Angina	Y	N	Diabetes	Y	N	Leukemia	Y	N
Heart Defect or Heart Murmur	Y	N	Excessive thirst	Y	N	Anemia	Y	N
Chest Pain	Y	N	Frequent urination	Y	N	Blood disorder	Y	N
Shortness of Breath	Y	N	Kidney Diseases	Y	N	Cancer	Y	N
Heart Surgery	Y	N	Eating Disorder	Y	N	Radiation therapy	Y	N
Implants (pacemaker, hip, knee, heart valve)	Y	N	Stomach Troubles/Ulcers	Y	N	Blood transfusion	Y	N
Swelling of Feet, Ankles, Hands	Y	N	Thyroid Problems	Y	N	Hepatitis/Jaundice	Y	N
Congenital Heart Problems	Y	N	Cortisone or steroid treatment	Y	N	Liver Disease	Y	N
Mitral Valve Prolapse	Y	N	Asthma	Y	N	Joint replacement	Y	N
Fainting or Dizzy Spells	Y	N	Hay Fever or Allergies	Y	N	Rheumatoid Arthritis	Y	N
Epilepsy or Seizures	Y	N	Lung or Breathing Problems	Y	N	Osteoarthritis	Y	N
Headaches or Migraines	Y	N	Emphysema	Y	N	Glaucoma	Y	N
Anxiety/Panic Attacks or Depression	Y	N	Snoring	Y	N	Tuberculosis	Y	N
Mental Health Care	Y	N	Persistent Cough	Y	N	AIDS or HIV infection	Y	N
Transient Ischemic Attack or Stroke	Y	N	Sinus or nasal problems	Y	N	Other _____	Y	N

What is your chief complaint? _____

Do you have problems with or experienced any of the following:

Bad breath, smell, or taste	Y	N	Dry mouth	Y	N	Grind or clench teeth	Y	N
Painful gums	Y	N	Bleeding gums	Y	N	Difficulty chewing food	Y	N
Spaces developing	Y	N	Sensitive teeth	Y	N	TMJ or jaw problems	Y	N
Receding gums	Y	N	Bite changing	Y	N	Accident-jaw/teeth	Y	N

Have you ever been treated for periodontal disease? Y N

If so, when and what procedures? _____

How many times a year do you have your teeth cleaned? _____

When was your last cleaning? _____

Additional medical or dental history not covered _____

Consent for anesthesia: I hereby give consent for local anesthesia given during treatment. I understand the risks, including nausea and vomiting and allergic or unexpected reactions. If severe, allergic reactions might cause more serious respiratory (lung) or cardiovascular (heart) problems which may require treatment. In addition, there may be, pain, swelling, inflammation or infection of the area of the injection, injury to nerves or blood vessels in the area, disorientation, confusion, or prolonged drowsiness after surgery and cardiovascular or respiratory responses which may lead to heart attack, stroke, or death. **Signature** _____

Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Today's Date: _____ Signature _____

Patricia Berube, D.M.D., M.S., P.A.
FINANCIAL POLICY

Thank you for choosing Dr. Berube as your provider. We are committed to providing excellent periodontal services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

1) You are financially responsible for your account.

- We will process your insurance benefits as a courtesy.
- **The first visit must be paid in full.** The remaining credit can be used for further treatment or can be refunded.
- **40% of nonsurgical and surgical treatment, along with unpaid deductibles and co-payments are due at the time of treatment. Some procedures must be paid in full.** A statement will be sent for balances that remain if your dental benefit plan pays less.
- All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- If the insurance company does not pay your claim after 60 days, a statement will be sent for the full balance, which will be due and payable at that time.
- I understand that employees of Patricia Berube, D.M.D., M.S. are **NOT** representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company.
- A dental benefit plan is an agreement between you, your employer and the insurance company. It is your responsibility to know and understand the level of services covered by your insurance company. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payment, covered charges, secondary, and "usual and customary charges".
- We charge the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- I authorize payment from my insurance carrier to be made directly to the periodontist. If payment is sent to me from the insurance company, I will forward it directly to the periodontist, as it is a theft of professional services if I keep the money. This is punishable by law and the account will be sent directly to collections.

2) It is your responsibility to provide us with your most current billing information.

- **Payment in full is due upon receipt of a statement, unless other arrangements have been made.** Balances older than 90 days may be subject to collection placement and fees or small claims court. Interest at 18% will begin to accumulate after 90 days. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- We understand that temporary financial problems and situations arise. We encourage you to communicate any such problems, so we may assist you in management of your account.

3) Rescheduling appointments: Kindly give 24 business hours notice if you must reschedule an exam or office visit. 72 hours (three business days) are required if you must reschedule a surgical procedure. If not, a fee will be incurred. **CLOSED FRIDAY.**

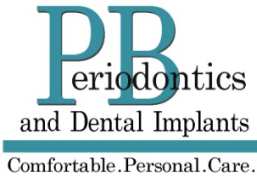
4) Lateness: If you are running late, kindly give us a phone call. If more than ten minutes late, we will try to accommodate you, but please understand that we may need to reschedule the appointment. A fee may be assessed if the problem is recurrent.

Full payment is due at the time of service. We accept cash, checks, credit cards and approved financing. I have read and understand this Financial Policy.

Patient or Guardian Signature

Printed name of patient

Date



Patricia Berube, D.M.D., M.S., P.A.
Acknowledgement of Receipt of
Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that Patricia Berube, D.M.D., M.S., P.A. reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website, www.dentonperio.com, and in the doctor's office. I may request a copy of the updated Notice of Privacy Practices by calling my doctor's office or requesting a copy in person at my appointment.

Patient's Printed Name

Date of Birth

Patient's/Legal Representative's Signature

Date

Relationship to Patient

Witness

Date

I wish to be contacted concerning appointments, treatment, financial issues and for all questions/concerns in the following manner (check all that apply):

- Home Telephone (please check one):
- Can leave message with detailed information
- Leave message with call-back number only

- Mobile Telephone (please check one):
- Can leave message with detailed information
- Leave message with call-back number only

- Work Telephone (please check one):
- Can leave message with detailed information
- Leave message with call-back number only

Email (use this address):

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Patricia Berube, D.M.D., M.S., P.A. to share my protected health information with:

Name

Relationship

Name

Relationship

Name

Relationship

Patricia Berube, D.M.D., M.S., P.A.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/31/2005, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a

request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.50 for each page, \$20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Patricia Berube, D.M.D., M.S.

Telephone: 940-384-7374 Fax: 940-384-7370

Address: 502 W. Oak St. Suite 102 Denton, TX 76201

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

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