Berry Road
Family Dentistry

635 North Berry Road
Norman, OK 73069
Phone: 405.329.7950
www.BerryRoadFamilyDentistry.com

Welcome to our dental office. We are very pleased to have you as a new patient.

We are here to provide you the optimum dental care possible. Should any emergency arise, please call immediately and we will see you the same day. Questions are always welcome so please feel free to ask.

We will be happy to file your insurance for you and accept assignment of benefits. We do ask that you pay your deductible and co-payment if applicable at the time of service unless prior arrangements have been made.

It is important to us that your care be delivered in an unhurried and professional way. In consideration of our other patients, 24-hour notice is needed for all appointment cancellations. After two missed appointments or same-day cancellations, a $60.00 charge maybe assessed to your account.

Please let us know how we can make you more comfortable. Nitrous oxide is always available for any procedure.

Again, welcome and thank you for your confidence.

Mitzi A. Roberts, DDS

_____ _____

Patient/Guardian Signature *Date*

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Insurance Policy:

As a courtesy, we will be happy to offer you an estimate of benefits to be paid by your insurance provider. This is an estimate only based on the information that you and your insurance company have provided to us; you will be responsible in full for the amount not covered for any reason by your insurance.

Financial Policy:

We share your concerns regarding the increasing cost of health care. We believe that you, our patients, expect and deserve the highest quality care we can provide at a reasonable cost. While we take advantage of every possible avenue to keep costs down, we are committed to not sacrificing quality for less expensive care. With this in mind, we would like to share some information with you about our financial policy. We want you to feel comfortable with us regarding your financial and insurance matters and thereby preventing any misunderstanding. We hope you will consult with us if you have any questions regarding our services and our financial policies.

Many people who have insurance think that the insurance company owes the doctor for services, not the patient. Please keep in mind that any insurance contract is between the patient and insurance company. Therefore, the patient is responsible for the bill, regardless of insurance coverage. As a courtesy to our patients, we are happy to bill your insurance for you. However, the responsibility for payment remains with the patient (or insured).

Patients With Insurance. At the time of treatment, patients are requested to make an initial payment toward the estimated charges. This amount will be based upon benefit information obtained from your insurance company, including but not limited to your deductible.

Patients Without Insurance. Patients without insurance are requested to pay the charges at the time of treatment unless other arrangements are established.

Account Balances. Charges are due and payable in full at the time of service. Balances on all accounts are due in full in 90 days regardless of insurance coverage or anticipated payment from other services. If payment for our services is not made within 90 days, an interest charge of 1.5% per month will be added to the account (18% per annum). Therefore, patients with insurance whose claims have not been paid within 45 days should contact their insurance company to determine the reason for delay of payment. Delinquent accounts may be referred for collections at the discretion of the financial coordinator.

By signing below you have read and understand the above financial information. The financial arrangements have been discussed with me. I accept financial responsibility for the procedures to be performed. I also understand that if I default on payment and can't be resolved with Berry Road Family Dentistry, I will also be charged service charges that will be greater than or equal to any court costs, attorneys' fees, collection agency fees, and/or any other costs associated with collecting any incurred debt. A copy of this signed agreement has been provided to me.

_____ _____

Patient/Guardian Signature *Date*

DENTAL REGISTRATION - HEALTH HISTORY

PATIENT INFORMATION

Date: _____
Patient Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Sex: ☐ M ☐ F
Single ☐ Married ☐ Widowed ☐
Divorced ☐ Minor ☐
Birthdate: _____
SS#: _____
Employer: _____
Address: _____
City: _____
State: _____ Zip: _____

Person responsible for account:
Name: _____
Address: _____
City: _____
State: _____ Zip: _____
SS#: _____ DOB: _____
Employer: _____
Address: _____
City: _____
State: _____ Zip: _____

For appointment confirmation:
☐ Email: _____
☐ Text to your cell: ( ) _____

INSURANCE INFORMATION

Policy Holder: _____
Relationship to patient: _____
SS#: _____ DOB: _____
Insurance Co: _____
Group/ID#: _____
Employer: _____
Patient covered by additional dental ins? ☐ Yes ☐ No
Policy Holder: _____
SS#: _____
Insurance Co: _____
Employer: _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Mitzi A. Roberts all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such informtion to the above-names insurance company(ies) and their agents for the purpose of obtaining payment for services and determing insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or responsible party

Date _____ Relationship to patient _____

PHONE NUMBERS

Home: ( ) _____ Work: ( ) _____ Ext_____ Cell: ( ) _____
Spouse's Work: ( ) _____ Best time to reach you _____
EMERGENCY CONTACT: (Specify someone who does not live in your household.)
Name: _____ Relationship: _____ Phone: ( ) _____

DENTAL HISTORY

Reason for today's visit:
_____
Former Dentist_____
City/State_____
Date of last visit _____
Date of last dental Xrays_____
Place a mark to indicate you have had any of the following:

☐ Bad breath
☐ Bleeding gums
☐ Blisters on lips or mouth
☐ Pain around the ear
☐ Burning sensation on tongue
☐ Clicking or popping jaw
☐ Dry mouth
☐ Fingernail biting
☐ Food collection between teeth
☐ Foreign objects
☐ Grinding teeth
☐ Gums swollen or tender
☐ Jaw pain or tenderness
☐ Lip or cheek biting
☐ Loose teeth or broken fillings
☐ Mouth breathing
☐ Mouth pain when brushing
☐ Periodontal treatment
☐ Chew on one side of mouth
☐ Sensitivity to cold
☐ Sensitivity to heat
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in your mouth
☐ Tobacco usage
☐ Orthodontic treatment

How often do you brush?
_____
How often do you floss?
_____

HEALTH HISTORY

Physicians's Name _____ Date of last visit _____

Have you ever taken any group of drugs collectively referred to as "fen-phen"? These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine). Pondimin (Fenfluramine) and Redux (Dexfenfluramine). ☐ Yes ☐ No

Place a mark to indicate if you have had any of the following:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Abnormal bleeding with extractions or Surgery
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, bloody or persistent
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen feet or ankles
- ☐ Swollen neck glands
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Unexplained weight loss

WOMEN:

Are you pregnant? ___ Due Date: _____ Are you nursing? _____

Taking Birth Control Pills ___

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

Pharmacy Name: _____

Phone: (☐) _____

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Other
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Barbiturates (sleeping pills)

_____

_____

OFFICE USE ONLY

Date: _____

Has there been any change in your health since you last appointment? ___ Yes ___ No

For what conditions? _____

Are you taking any new medications? ___ Yes ___ No If so, what? _____

_____

Comments: _____

Berry Road Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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

_____
(Signature)

_____
(Date)

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:

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

_____
_____
_____