Dr. Daniel M. Bergeron D.D.S., PC

Patient Information **Today's Date**_____

Please check one**:**
Are you the Patient []
or the Parent/ Guarantor []

Patient Name_____
(First) (Middle Initial) (Last)

Gender: Male [] Female [] Birthdate_____

Single [] Married [] Divorced [] Widowed [] Partnered for _____ years

Mailing Address_____ City_____ State_____

ZIP_____ Home Phone (_____)_____ Cell hone(_____)_____

Patient or parent's employer _____ Occupation_____

Work phone (_____)_____

Name of previous dentist_____

City of previous dentist_____ State_____

Previous dentist's telephone number (_____)_____ Date of last dental exam:_____

Incase of emergency, who should be notified? _____

Phone (_____)_____ Relationship to person_____

Whom may we thank for referring you? _____

If the patient is a minor or student, please complete the following:

Name of Mother_____ Name of Father_____
(First, middle initial , last) (First, middle initial , last)

Parents are (Check one)
[] Single [] Married [] Separated [] Divorced [] Partnered for _____ years

Students School / College_____ City_____ State_____

If your child plays sports, what sports do they play?_____

What are your child's hobbies/interests?_____

Insurance Information

Patient's name _____ Birthdate_____
(First) (Middle Initial) (Last)

SS#_____

Subscriber of insurance information

Subscriber' of Name _____
(First) (Middle Initial) (Last)

Subscriber's address (if different from the patient's)_____

City_____ State_____ Zip_____

SS#_____ Birthdate_____ Employed by_____ Union or Trust_____

Employers address_____ Employers Phone_(_____)_____

Occupation_____ Employed for (How long) _____years and _____Months

Insurance Company_____ Group #_____

Subscriber/ Member or ID #_____

What is your dental plan maximum annual benefit?_____

How much is your dental plan deductible?_____

How much have you used for this benefit period?_____

Please list additional dependents under this insurance policy (please ask for additional form to list members/dependents if needed):

1._____
(First) (Middle initial) (Last) (Birthdate) (Relationship to insured person)

2._____
(First) (Middle initial) (Last) (Birthdate) (Relationship to insured person)

3_____
(First) (Middle initial) (Last) (Birthdate) (Relationship to insured person)

4._____
(First) (Middle initial) (Last) (Birthdate) (Relationship to insured person)

Member/patient signature_____ **Date** _____

Daniel M. Bergeron D.D.S., PC

Daniel M. Bergeron D.D.S., PC
Treatment Authorization and Release

It is our goal as your primary dental health care provider to deliver the best dental health care possible. In order for us to provide our patients with quality dental health care we require that new patients have an initial appointment that will include a complete oral evaluation and acquisition of appropriate diagnostic information. Diagnostic information may include but is not limited to appropriate radiographs (x-rays) for diagnosis of hard tissue (teeth/bone) disease / decay /bone level, oral exam to evaluate the soft tissue (cheek, tongue, gingival/gum tissue) and hard tissue (teeth/bone) for state of health, possible lesions and or decay/disease, periodontal readings to evaluate the periodontal health surrounding your teeth. For new patients who have had bitewing x-rays in the last 12 months and a pano/ Full mouth set of radiographs in the last 36 months (bitewing radiographs must be no more that 12 months old) we will try to obtain them from your previous healthcare provider given that you have signed a records release form with their office or with ours indicating that we may do so. If the radiographs are of poor quality or the image is unreadable we may need to retake some or all of the radiographs in order to properly diagnose the state of your oral health. As an established patient it is our policy that bitewing radiographs are taken annually (once every twelve months) and not to exceed 36 months on a patient to patient basis.

It is our responsibility as your dental health care provider to inform you of our findings and present treatment options. Dentistry is not an exact science and while we use diagnostic information to best evaluate our patients, diagnose their state of oral health and needed treatment, there is always the possibility that upon access of soft or hard tissue additional findings such as more extensive decay may present itself, which may change the original diagnosis of needed dental treatment. We will inform the patient and or guarantor of any additional findings upon the course of treatment that were not initially diagnosed. It is our goal to provide quality dental health care to all of our patients and to provide you with information so that you can make informed decisions in regards to your dental health care treatment option. As a patient you have the right to refuse advised treatment prior to hard tissue access and in doing so you accept that there be no liability against Daniel M. Bergeron D.D.S., PC.

Appointments: As a courtesy we place reminder calls to our scheduled patients two business days prior to their scheduled appointment. We place the calls two business days prior to the scheduled appointment to allow ample time for a patient to contact us if they should need to cancel or reschedule their appointment. This allows us to contact and schedule patients who are on our call list and offer them a much needed appointment time. Your consideration for this policy and to cancel an appointment in a timely manner is greatly appreciated by our staff and other patients in need of an appointment. **We have a strict less than 24 hours notice cancelation and no show policy. Patients who have two less than 24 hours notice cancelations and or no shows on their account are subject to being dismissed as a patient.**

Thank you for choosing Daniel M. Bergeron D.D.S., PC for your dental health care provider.

I _____have read, understand and give my consent to the above.
(Please print patient/guarantor name)

Name of Patient if different from above:_____

Signature of Patient / Garantor:_____

Relationship to patient_____ Date:_____

Daniel M. Bergeron Financial Policy, Authorization and Release.
The following is inclusive to the parent / guardian of minors.

Payment for services, treatment and or products received is due in full at the time of receipt unless prior financial arrangements have been made by the office manager. Should financial arrangements be made, an additional $5.00 fee will be added monthly to the outstanding balance of the account.

Our office accepts cash, checks, Visa, Master Card, and Discover. Any returned checks due to nonsufficient funds will have a $25.00 charge added to the account in which the payment was intended for.

If you have dental insurance coverage **please remember:**

Your policy is between you and your insurance company.
Your deductible and estimated portion of payment for treatment, services or products received is due at the time in which they are received. As the insurance policy subscriber/member **it is your responsibility to know and to understand your dental insurance coverage, limitations and overall benefits**.

It is the covered member's responsibility to notify administrative staff of any insurance coverage and or changes and to provide them with the correct insurance information in order for your insurance company to be billed on your behalf.

As a courtesy we are happy to file dental claims/bill your insurance company(s) for treatment rendered and help you inquire information in regards to your dental coverage.
Any account with a 60 day lapse of payment after our office has received the final payment or nonpayment explanation of benefits from your insurance company is subject to collection. If your account is sent to a collection agency, a 35% fee will be assessed.

I (please print your full name):_____
Certify that I, and/or my dependent(s), have insurance coverage as indicated on the insurance forms submitted, signed, dated and assign directly to **Dr. Bergeron D.D.S., PC** all insurance benefits, if any, 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. I understand that if I do not have dental insurance coverage that payment for treatment and or dental related services are due at the time I am treated.

Primary Insurance company name_____
Secondary insurance company name_____
Third insurance company name_____

The above-named dentist may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my dental insurance is terminated, my dental records are released to another dentist for my continuation of primary dental care else where upon my request or should I be dismissed as a patient.

Patient/Guarantor name (**please print**):_____

Name of Patient if different from above:_____

Signature of Patient / Garantor:_____

Relationship to patient_____

Date:_____

PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____
HOME ADDRESS _____ DATE OF BIRTH _____
_____ HOME PHONE _____
E-MAIL _____ CELL PHONE _____
EMPLOYER _____ BUSINESS PHONE _____
INSURANCE CO. _____ SS#/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use alcohol, cocaine or other drugs?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following?

	YES	NO		YES	NO		YES	NO
Local anesthetics (eg. novocaine)	☐	☐	Barbiturates	☐	☐	Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐	Other _____	☐	☐
Sulfa Drugs	☐	☐	Iodine	☐	☐	_____		

9. WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ ☐

11. Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low/High Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Mitral Valve Prolapse	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	_____	☐	☐

COMMENTS

_____

_____

_____

_____

_____

_____

Signature of Dentist Date

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

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.

SIGNATURE X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

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Relationship to patient_____ Date:_____

DANIEL M. BERGERON, DDS, PC
3112 AIRPORT WAY, SUITE TWO
FAIRBANKS, ALASKA 99709-4773
907.456.5600
DBERGERONDDSPC@ICLOUD.COM

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 15 August 2017, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

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

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved In Your Care or Payment for Your Care.

We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

• Prevent or control disease, injury or disability;

• Report child abuse or neglect;

• Report reactions to medications or problems with products or devices;

• Notify a person of a recall, repair, or replacement of products or devices;

• Notify a person who may have been exposed to a disease or condition; or

• Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your

information.

Coroners, Medical examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures ofyour health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply**. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative communication. You have the right to requestthat we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we

have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

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 if you disagree with a decision we made about access to your health information or in response to a request youmade 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.

Our Privacy Official: _____

Telephone: _____ FAX: _____

Address: _____

Email: _____

DANIEL M. BERGERON, DDS, PC
3112 AIRPORT WAY, SUITE TWO
FAIRBANKS, ALASKA 99709-4773
907.456.5600
DBERGERONDDSPC@ICLOUD.COM

Acknowledgement of Receipt of Notice of Privacy Practices

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

Print Name: _____

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)

_____

_____

_____