Consent for Use and Disclosure of Health Information

Purpose: In cases where Gregory T. Berg, D.D.S. has directed not to reply on Acknowledgments as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

GREGORY T. BERG, D.D.S.
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other information matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Marie Haskins, Office Manager
Telephone: (636) 928-6000 Fax: (636) 928-6011
Address: 1325A Queens Ct. St. Peters, MO 63376

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance of this Consent before we received your revocation, and that your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:
Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

This information is requested to help us give you the best possible care, it is very important, and of course, CONFIDENTIAL.

Please Print

Patient's Name: _____ Date of Birth: _____

Spouse or Parent Name: _____

Home Address: _____ Home Phone: _____

City: _____ Zip: _____ Apt. No.: _____

Insured Employer: _____ Bus. Phone: _____

Business Address: _____

Name of Referring Dentist: _____

Dental Insurance Co., If any, _____

Patient's S.S. Number: _____

Insured Social Security No.: _____ Date of Birth: _____

Individual Responsible for Payment: _____ Phone: _____

Are you in good physical health? Yes No
Are you under the care of a physician? Yes No
Are you taking any medication or pills of any kind? Yes No If so, what? _____

Are you allergic to any of the following?

Penicillin	Yes	No	Iodine/Seafood	Yes	No	Barbiturates,	Yes	No
Aspirin	Yes	No	Bleach	Yes	No	Local anesthetic (novocaine)	Yes	No
Codeine	Yes	No	Latex	Yes	No	Other drugs or medicines	Yes	No

If so, please list _____

PLEASE CIRCLE ANSWERS.

Have you ever had any of the following?

Rheumatic Fever	Yes	No	Artificial Joints	Yes	No
Heart Trouble	Yes	No	High or Low Blood pressure	Yes	No
Heart Murmur	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Respiratory problems	Yes	No
Diabetes	Yes	No	Liver disease	Yes	No
Arthritis	Yes	No	Ulcer	Yes	No
Thyroid Condition	Yes	No	Kidney	Yes	No
Major Operation	Yes	No	Pacemaker	Yes	No
Hepatitis	Yes	No	Other	Yes	No
Bleeding tendencies	Yes	No	Are you pregnant?	Yes	No
Venereal Disease	Yes	No	Month _____		
Seizures	Yes	No	Aids/HIV	Yes	No
Psychiatric Problems	Yes	No			

Antibiotic premedication required. Yes No _____ (initials) I agree to premed prior to each visit.

Is there any other information about your health that we should know? Yes No
What?

_____

INFORMED CONSENT

I understand Root Canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had Root Canal therapy may require retreatment, surgery, or even extraction.

I also understand that only the root canal treatment is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, etc.) will be done by my regular dentist.

I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT or BEFORE COMPLETION, unless other specific arrangements are made with the secretary.

I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize release of any information necessary to process dental insurance.

Signed: PATIENT, PARENT or AGENT _____

DATE _____

REVIEWED BY: _____ Date: _____