

# PATIENT REGISTRATION INFORMATION

Kevin D Burgdorf DDS, LLC  
 2050 Bluestone Drive  
 St. Charles, MO 63303  
 Phone: 314-291-9000

**PATIENT INFORMATION**

NAME: \_\_\_\_\_ MARRIED SINGLE DIVORCED WIDOWED  
LAST FIRST MI  
 SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ MALE FEMALE  
MONTH DAY YEAR  
 ADDRESS: \_\_\_\_\_  
STREET APT# CITY STATE ZIP  
 HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
 EMAIL: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
 NAME of EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

**PRIMARY INSURED** /IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

\_\_\_\_\_  
LAST FIRST MI  
 \_\_\_\_\_  
STREET  
 \_\_\_\_\_  
CITY STATE ZIP  
 \_\_\_\_\_  
HOME WORK  
 \_\_\_\_\_  
CELL EMAIL  
 \_\_\_\_\_  
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT  
 \_\_\_\_\_  
EMPLOYER  
 \_\_\_\_\_  
DENTAL INS CO  
 \_\_\_\_\_  
SS# SUBSCRIBER # GROUP #

**SECONDARY INSURED**

\_\_\_\_\_  
LAST FIRST MI  
 \_\_\_\_\_  
STREET  
 \_\_\_\_\_  
CITY STATE ZIP  
 \_\_\_\_\_  
HOME WORK  
 \_\_\_\_\_  
CELL EMAIL  
 \_\_\_\_\_  
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT  
 \_\_\_\_\_  
EMPLOYER  
 \_\_\_\_\_  
DENTAL INS CO  
 \_\_\_\_\_  
SS# SUBSCRIBER # GROUP #

**PERSON TO CONTACT IN CASE OF EMERGENCY**

**AUTHORIZATION**

NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY/STATE/ZIP: \_\_\_\_\_  
 TELEPHONE: \_\_\_\_\_

I hereby authorize payment directly to Kevin D Burgdorf DDS, of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Kevin D Burgdorf DDS to administer such medications and perform such diagnostic photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/ medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

**Whom may we thank for referring you to our office?**  
 \_\_\_\_\_

\_\_\_\_\_  
 Patient or Responsible Party Date

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Date Created: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?  Yes  No If yes \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No If yes \_\_\_\_\_

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  Yes  No If yes \_\_\_\_\_

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: \_\_\_\_\_

X

Date: \_\_\_\_\_

# HIPAA NOTICE OF PRIVACY PRACTICES

## 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information or dental health or condition and related dental care services.

### **Uses and disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing dental care services to you, to pay your dental care bills, to support the operation of the dentist's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed to obtain payment for your dental care services

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law. Communicable diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights:** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or dental operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your protected health information, you protected health information will not be restricted. You then have the right to use another Dental Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.** Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your dentist amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of you complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Kevin D. Burgdorf DDS  
2050 Bluestone Drive  
St. Charles, MO 63303  
Phone: (314)291-9000

# Kevin D Burgdorf DDS, LLC

## OUR POLICY OF CARE AND PAYMENT

Ensuring that our patients receive high quality care is the goal of our practice.

### Payment is due at the time of treatment.

We accept cash, check, and major credit cards (Master Card, Visa, & Discover). We also offer payment plans available to you through Care Credit. That will allow you to start treatment today and spread payments over time.

### Failed Appointment Policy

#### There is a \$100 cancelation fee per scheduled hour.

As you know we only see 4-8 patients per day, therefore appointment time is a precious commodity to our patients. When a patient fails to call and reschedule or just fails to show up for their appointment, this delays other patients who really want to continue their journey to optimal health.

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments. If you are unable to do so, please notify us at least 24 hours in advance. When you provide us with 24 hours notice we are able to accommodate other patients in need of treatment.

### Please read our policy as indicated below:

Cancellations are requested with 24 hours notice; otherwise it is considered a missed appointment.

- First missed appointment – We realize patients get sick, people sometimes forget, or another emergency arises. As soon as you are aware that you can't make the appointment, call us – even late at night you are able to leave a message on our answering machine. Typically, we don't charge for the first missed appointment; however, we do reserve the right to do so.

- Second missed appointment – A missed appointment fee of \$100.00 per scheduled hour will be charged to your account. This will be charged per family member if multiple appointments scheduled and broken.

Please note: Insurance will not pay for this charge. We require the missed appointment fee be paid in full before scheduling another appointment.

- Third missed appointment - You will be charged another \$100.00 per scheduled hour missed appointment fee. In addition, we also reserve the right to dismiss you from our practice.

Note: Parents bringing in two or more family members at the same time will be restricted from scheduling a double or triple appointment after missing appointments for multiple family members.

I have read and agree to the Financial Policy and Failed Appointment Policy of Dr Kevin D Burgdorf DDS.

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date

**Berlin Questionnaire<sup>®</sup>**  
**Sleep Apnea**

Height (m) \_\_\_\_\_ Weight (kg) \_\_\_\_\_ Age \_\_\_\_\_ Male / Female

Please choose the correct response to each question.

**Category 1**

**1.** Do you snore?

- a. Yes
- b. No
- c. Don't know

*If you answered 'yes':*

**2.** You snoring is:

- a. Slightly louder than breathing
- b. As loud as talking
- c. Louder than talking

**3.** How often do you snore?

- a. Almost every day
- b. 3-4 times per week
- c. 1-2 times per week
- d. 1-2 times per month
- e. Rarely or never

**4.** Has your snoring ever bothered other people?

- a. Yes
- b. No
- c. Don't know

**5.** Has anyone noticed that you stop breathing during your sleep?

- a. Almost every day
- b. 3-4 times per week
- c. 1-2 times per week
- d. 1-2 times per month
- e. Rarely or never

**Category 2**

**6.** How often do you feel tired or fatigued after your sleep?

- a. Almost every day
- b. 3-4 times per week
- c. 1-2 times per week
- d. 1-2 times per month
- e. Rarely or never

**7.** During your waking time, do you feel tired, fatigued or not up to par?

- a. Almost every day
- b. 3-4 times per week
- c. 1-2 times per week
- d. 1-2 times per month
- e. Rarely or never

**8.** Have you ever nodded off or fallen asleep while driving a vehicle?

- a. Yes
- b. No

*If you answered 'yes':*

**9.** How often does this occur?

- a. Almost every day
- b. 3-4 times per week
- c. 1-2 times per week
- d. 1-2 times per month
- e. Rarely or never

**Category 3**

**10.** Do you have high blood pressure?

- Yes
- No
- Don't know