PATIENT REGISTRATION INFORMATION

Kevin D Burgdorf DDS, LLC
12266 DePaul Drive, Suite 325
Bridgeton, MO 63044
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

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____

Whom may we thank for referring you to our office?

_____

AUTHORIZATION

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.

_____
Patient or Responsible Party Date

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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 _____ DATE _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCTIBES 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 complied 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
12266 De Paul Drive, Ste 325
Bridgeton, MO 63044
Phone: (314)291-9000

Kevin D. Burgdorf DDS
12266 DePaul Dr. Suite 325E
Bridgeton, MO 63044

BERLIN QUESTIONNAIRE

Name:_____ Date:_____

Height _____ Weight _____ 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 snore:

2. Your snoring is:
_ a. Slightly louder than breathing
_ b. As loud as talking
_ c. Louder than talking
_ d. Very loud – can be heard in adjacent rooms

3. How often do you snore
_ a. Nearly every day
_ b. 3-4 times a week
_ c. 1-2 times a week
_ d. 1-2 times a month
_ e. Never or nearly never

4. Has your snoring ever bothered other people?
_ a. Yes
_ b. No
_ c. Don't Know

5. Has anyone noticed that you quit breathing during your sleep?
_ a. Nearly every day
_ b. 3-4 times a week
_ c. 1-2 times a week
_ d. 1-2 times a month
_ e. Never or nearly never

CATEGORY 2

6. How often do you feel tired or fatigued after your sleep?
_ a. Nearly every day
_ b. 3-4 times a week
_ c. 1-2 times a week
_ d. 1-2 times a month
_ e. Never or nearly never

7. During your waking time, do you feel tired, fatigued or not up to par?
_ a. Nearly every day
_ b. 3-4 times a week
_ c. 1-2 times a week
_ d. 1-2 times a month
_ e. Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
_ a. Yes
_ b. No
If yes:

9. How often does this occur?
_ a. Nearly every day
_ b. 3-4 times a week
_ c. 1-2 times a week
_ d. 1-2 times a month
_ e. Never or nearly never

CATEGORY 3

10. Do you have high blood pressure?
_ Yes
_ No
_ Don't know

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.

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_____ _____

Signature of Patient/Responsible Party Date