BENNARDI & BARBERIO

42 S Main St,
Muncy PA 17756

PATIENT INFORMATION

Name_____

Preferred Name_____

Address_____

_____

Home Phone_____

Cell Phone_____

Work Phone_____

Employer_____

Dental Insurance Co_____

Subscriber Name:_____

Subscriber #_____

Group #_____

___ Married ___Single ___Minor

___ Male ___ Female

Date of Birth_____

Social Security #_____

Whom may we thank for referring you to our office?

_____

E-mail address_____

CONTACT–IN CASE OF EMERGENCY

Outside of Immediate Household/Family

Name_____

Address_____

Phone_____

FAMILY INFORMATION
Fill in Both Father and Mother for Minor Child

Father (or Husband)

Name_____
Address_____
Home Phone_____
Cell Phone_____
Work Phone_____
Date of Birth_____
Social Security #_____
Employer_____
Dental Insurance_____
Group #_____
E-Mail_____

Mother (or Wife)

Name_____
Address_____
Home Phone_____
Cell Phone_____
Work Phone_____
Date of Birth_____
Social Security #_____
Employer_____
Dental Insurance_____
Group #_____
E-Mail_____

AUTHORIZATION

I hereby authorize payment directly to Bennardi, Barberio of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic 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 health professionals.

X_____
__Adult Patient __Father (Or Husband) __Mother (Or Wife) __Guardian

Date : _____

SERVICE CHARGE

I understand that if I do not pay my entire balance within 25 days of the monthly billing dated, an interest charge will be added to my account. The interest charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last month's balance. In the case of default or payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding balances.

X_____
__Adult Patient __Father (Or Husband) __Mother (Or Wife) __Guardian

Patient Name

Bennardi, Barberio
42 S Main St, Muncy PA 17756

Physician: Physician Phone:

Pharmacy: Pharmacy Phone:

Primary reason for this dental appointment? _____

DENTAL HISTORY

Please answer the following about your dental history. Please explain your answers.

Y	N			Y	N		
☐	☐	Brush regularly		☐	☐	Gum disease	
☐	☐	Bruxing		☐	☐	Loose teeth	
☐	☐	Chew tobacco		☐	☐	Negative dental experiences	
☐	☐	Decay		☐	☐	Nice Smile	
☐	☐	Dental Problems		☐	☐	Positive dental experiences	
☐	☐	Dental X-rays regularly		☐	☐	Smoke cigarettes	
☐	☐	Floss regularly		☐	☐	Recreational Alcohol Use	
☐	☐	Food Traps		☐	☐	TMJ problems	
☐	☐	Grinding		☐	☐	Visit dentist regularly	
Specific Dental Problems:				☐	☐	Want to keep remaining teeth	

MEDICAL HISTORY

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant?
☐	☐	Are you nursing?

Height _____
Weight _____

Office Use Only

BP	Heart Rate

ALLERGIES

Y	N	
☐	☐	Aspirin
☐	☐	Acrylic
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other _____

MEDICATIONS/ VITAMINS

Name	Dosage	Frequency	Doctor

Dates of Hospitalizations and/or major surgeries:

Are you currently under a doctor's care? Please explain.

Patient Name: Office Use Only:

Medical Alerts

Do you now have or have you ever had any of the following? Please explain if you answer yes.

If you have any of the conditions in bold please call our office prior to your appointment you may need to premedicate.

Y	N			Y	N		
☐	☐	Abnormal Bleeding		☐	☐	Hepatitis A (Infectious)	
☐	☐	AIDS		☐	☐	Hepatitis B or C	
☐	☐	Alcohol Abuse		☐	☐	Herpes	
☐	☐	Alzheimer's Disease		☐	☐	High Blood Pressure	
☐	☐	Anemia		☐	☐	HIV Positive	
☐	☐	Angina/Chest Pain		☐	☐	Hive or Rash	
☐	☐	Arthritis/Gout		☐	☐	Hypoglycemia	
☐	☐	***Artificial Heart Valve***		☐	☐	Injury to head or neck	
☐	☐	***Artificial Joint***		☐	☐	Irregular Heart Beat	
☐	☐	Asthma		☐	☐	Kidney Problems	
☐	☐	Been hospitalized		☐	☐	Leukemia	
☐	☐	Blood Disease		☐	☐	Liver Disease	
☐	☐	Bruise Easily		☐	☐	Low Blood Pressure	
☐	☐	Cancer		☐	☐	Lung Disease	
☐	☐	Chemotherapy		☐	☐	Major Surgery	
☐	☐	Cold Sores		☐	☐	***Mitral Valve Prolapse***	
☐	☐	Colitis		☐	☐	MRSA Infection	
☐	☐	Congenital Heart Disorder		☐	☐	Nervousness	
☐	☐	Convulsions		☐	☐	Pain in Jaw Joints	
☐	☐	Cosmetic Surgery		☐	☐	Psychiatric Care	
☐	☐	Dairy Allergy		☐	☐	Recent Weight Loss	
☐	☐	Diabetes		☐	☐	Renal Dialysis	
☐	☐	Drug Addiction		☐	☐	***Rheumatic Fever***	
☐	☐	Emphysema		☐	☐	Rheumatism	
☐	☐	Epilipsy or Seizures		☐	☐	Scarlet Fever	
☐	☐	Excessive Bleeding		☐	☐	Shingles	
☐	☐	Excessive Thirst		☐	☐	Shortness of Breath	
☐	☐	Fainting or Dizziness		☐	☐	Sickle Cell Disease	
☐	☐	Fever Blisters		☐	☐	Sinus Trouble	
☐	☐	Frequent Cough		☐	☐	Special Diet	
☐	☐	Frequent Diarrhea		☐	☐	Stomach/Intestinal Disease	
☐	☐	Frequent Headaches		☐	☐	Stroke	
☐	☐	Genital Herpes		☐	☐	Swelling of the limbs	
☐	☐	Glaucoma		☐	☐	Thyroid Disease	
☐	☐	Hay Fever		☐	☐	Tuberculosis	
☐	☐	Heart Attach/Failure		☐	☐	Tumors or Growths	
☐	☐	***Heart Murmur***		☐	☐	Ulcers	
☐	☐	***Heart Pace Maker***		☐	☐	Under doctors care	
☐	☐	***Heart Surgery***		☐	☐	Venereal Disease	
☐	☐	Heart Trouble/Disease		☐	☐	X-ray Treatments (Radiation)	
☐	☐	Hemophilia (Bleeding Problem)		☐	☐	Yellow Jaundice	

Other serious illness not listed _____

To the best of my knowledge, all of the preceding answers on both pages are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Signed: _____ __Adult Patient __Father (or Husband) __Mother (or Wife) __Guardian

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Dear Valued Patient,

We are dedicated to providing you with the best possible treatment and care. As always, we are happy to discuss our services and policies with you. It is important to our professional relationship that you clearly understand our financial policy. Please ask if you have any questions about our fees, policies, or your responsibility.

The following is an overview of our financial policy. We ask that you review this and then sign it, verifying that you have read and understand our policy.

FINANCIAL POLICY

For our patients with dental insurance:
We will continue to aid you by processing your insurance claims to maximize your benefits, and submit to those carriers who remit directly to us. You continue to be responsible for the payment of the **estimated portion of your bill** at the time of service. Please be aware that we **cannot guarantee** that the procedures you are having done at any time will be covered by your insurance plan. You will be responsible for additional balance that may be due after the insurance portion has been received by our office. If you have questions about the portion that your insurance will cover, we ask that you contact your insurance carrier or benefit handbook prior to your appointments. Further, we ask that if you are not prepared to pay your balances or co-pays at the time of service that you reschedule your appointment. We accept VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS in addition to cash, checks and debit cards with the VISA and MASTERCARD logo. We will bill your insurance carrier for 60 days for any service. After that time, the balance will be billed to the patient.

When arriving at our office, please notify us if you have had any changes in name, address, phone number, employer, or insurance carrier. With the industry changes due to HIPAA, insurance companies are issuing new employee identification numbers, so please let us know when you receive your new card. It is also very important that we have a social security number on file for every member of your family including children also for HIPAA regulations.

For our patients without dental insurance:

Patients without insurance are responsible for the cost of treatment at the time of service. In addition to cash and checks, we accept VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS. We can process debit cards with the VISA or MASTERCARD symbol on them. We ask that if you are not prepared to pay for your services at the time of treatment that you reschedule your appointment.

When arriving, please notify us of any changes in name, address, phone number, or employer. We do need to have a social security number on file for all members of your family as part of the HIPAA regulations.

For all patients:

Please note that we continue to charge 1.5% monthly (18% APR) on all balances not paid within 30 days. If you are having treatment that is more extensive, and wish to discuss additional payment options, please ask a member of our business staff.

A 24-hour notice is required for cancellation of appointments. Any appointments cancelled with less than 24 hours notice are subject to a $75 missed appointment fee.

Again, if you have any questions about this or any other policies please ask. We are here to help you, and provide you with high quality dental care.

_____ _____

Signature of Patient/Responsible Party Date

BENNARDI & BARBERIO

Authorization for Use or Disclosure of Patient Photographic and/or Video Images

Authorization:

I authorize Bennardi, Barberio, Bennardi PC the use and disclosure of my name (first name only), photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

- ◯ Yes, I authorize use of material. _____(initial)
- ◯ No, I decline use of material. _____(initial)

Purpose:

The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Practice Name: Bennardi, Barberio, Bennardi PC

Patient Name: _____

Date: _____

Signature Patient/Legal Guardian: _____

INFORMED CONSENT

LOCAL ANESTHESIA & CHLORHEXIDINE

I give my consent to Dr. Mary C. Bennardi/Dr. Thomas F. Barberio to use local anesthetics that the dentist may deem necessary or advisable to enable the providers of service to render dental treatment as indicated on my examination chart, which I acknowledge by my signature below. I also give consent for any dentist or hygienist to irrigate the mouth when necessary with the prescriptive rinse Chlorhexidine. Please notify your provider if there is an allergy to Chlorhexidine. When necessary, this rinse is used to help fight against the bacteria which causes periodontal disease. Additionally, any other procedure deemed necessary or advisable as a corollary to the planned treatment for the below named individual.

I understand that occasionally there are complications involved in this type of treatment and/or the use of anesthesia agents: including, but not limited to: numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, nerve damage, stroke or cardiac arrest. I further understand and accept that complications may require hospitalization and may even result in death.

Patient/Legal Guardian Signature_____Date_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have read the notice and/or received a copy of this office's Notice of Privacy Practices.

_____
{Please 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)

_____

_____

Bennardi Barberio, PC

NOTICE OF 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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (03/30/03), 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner, and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 for each page, $10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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

Contact Officer: Thomas Barberio, DMD

Telephone: 570-546-3419 Fax: 570-546-7172

E-mail: bennardibarberio@comcast.net

Address: 42 S Main St, Muncy PA 17756

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DEALING WITH DENTAL EMERGENCIES

Knocked-Out Tooth:

- Hold the tooth by the crown, and rinse off the root of the tooth if it's dirty. Do not scrub it or remove any attached tissue fragments. If it's possible, gently insert and hold the tooth in its socket. If that isn't possible, put the tooth is a cup of milk or water and get to the dentist as quickly as possible. Don't forget to take the tooth with you!

Broken Tooth:

- Rinse your mouth with warm water to keep the area clean. Put cold compresses on your face to reduce swelling if present. Call the dentist to schedule and appointment.

Bitten Tongue or Lip:

- Clean the area gently with a cloth, and apply cold compresses to keep swelling down. If bleeding doesn't stop, go to a hospital emergency room.

Objects Caught Between Teeth:

- Gently try to remove the object with dental floss. If you're not successful, call the dentist to schedule and appointment. Do not try to remove the object with a sharp or pointed instrument.

Toothache:

- Rinse your mouth with warm water to clean it out. Use dental floss to remove any food that may be trapped between the teeth. Do not put aspirin on the aching tooth or gum tissues. Call your dentist to schedule an appointment.

Possible Broken Jaw:

- Do not move the jaw. Secure the jaw in place by tying a handkerchief, necktie, or towel around the jaw and over the top of the head. If there is swelling, apply cold compresses. Go to the hospital emergency room immediately.

If a dental emergency happens while you are traveling:

- Look in the Yellow pages under "dentist" to find the state or local dental society phone number to get a referral
- Ask the hospital emergency room to recommend a dentist.
- If you are out of the country, contact the U.S. Embassy or ask hotel personnel to refer you to a dentist.

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INFECTION CONTROL

This information is provided to inform you about measures we have taken in our office to reduce the chances of cross-contamination of disease from patient to patient. You will note numerous areas of prevention you may not have seen before. Included among them are:

1. **Facemasks**: All our clinical personnel wear facemasks during active patient care. These physical barriers assist in reducing the spread of organisms from person to person.

2. **Gloves**: New rubber gloves are worn for every patient. These gloves assure you of no contamination from other patients.

3. **Disinfection of Counters and Other Surfaces**: You may notice a mild chemical odor associated with wiping surfaces. These chemicals are necessary to disinfect surfaces that are touched during patient treatment.

4. **Items Attached to Dental Operating Units**: Handpieces, air blowers, suction equipment, etc. are sterilized by a combination of heat and chemicals.

5. **Barriers**: Plastic, rubber or paper is placed on switches, etc. for each new patient.

6. **Instruments**: All metal instruments placed in your mouth have been sterilized by a combination of heat and chemicals. All plastic items are new for each patient.

We assure you that every precaution is being taken to avoid any cross-contamination from patient to patient. We welcome your suggestions.

Thank you.