Karen D. Barwick, DDS PA
Christopher D. Berry, DDS

150 West Crescent Square Drive
Graham NC 27253
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NEW PATIENT FORMS

First Name Last Name Preferred Name

Address

Preferred Phone (H) (C) (W)

Email DOB Gender

Emergency Contact & Phone Number Marital Status

Who referred you to our office? _____ Do you have dental insurance? ☐ Yes ☐ No

Name of Primary Insured Primary Insured DOB

Primary Insured Employer Name

Primary Insured Phone (H) (W)

Insurance Co. Group # ID #

Physician's Name Physician's Phone

Pharmacy Pharmacy Phone

Previous Dentist's Name Previous Dentist's Phone

Date of Last Dental Exam Date of Last Dental X-rays

Do you use tobacco? ☐ Yes ☐ No If yes, do you use ☐ Cigarettes/Cigars ☐ Smokeless/Dip ☐ Vape

If female: Are you taking Birth Control Pills? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

If female: Are you pregnant? ☐ Yes ☐ No If pregnant, how many weeks?_____

Allergies: Please check all that apply.

☐ Aspirin ☐ Dental Anesthetics ☐ Jewelry ☐ Metals ☐ Tetracycline
☐ Codeine ☐ Erythromycin ☐ Latex ☐ Penicillin

Do you have any allergies not listed above?

Condition: Please check all that apply.

- ☐ Abnormal Bleeding
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Diseases
- ☐ Cancer (Chemotherapy /Radiation)
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ HIV/AIDS
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Pain in Jaw Joints
- ☐ Pneumocystitis
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Yellow Jaundice
- ☐ Osteoporosis
- ☐ Fear or Anxiety about Dental Treatment
- ☐ Other, please list below

Please list all medications including non-prescription drugs and herbal supplements.

Please list recent hospitalizations.

Have you ever had joint replacement? ☐ Yes ☐ No

If yes, which joint and date of replacement?

Do you currently take antibiotics prior to dental treatment? ☐ Yes ☐ No

If yes, for what condition?

If yes, please give the name and dosage of the antibiotic.

Is there any disease, condition, or problem that you think this office should know about that is not covered above?

Additional Comments

Signature or Guardian Signature (if under 18) **Date**

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Karen Barwick and/or Associates or Assistants of her choice to perform needed treatment(s)/procedure(s).

I further request and authorize the taking of oral dental images and the use of such anesthetics as may be considered necessary and/or advisable by the doctor responsible for my/the patient's treatment.

I have had explained to me, and I have had sufficient opportunity, to discuss my/the patient's dental condition(s)/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected for this treatment, compared with alternative approaches and/or no treatment.

The usual and most frequent risk or complications occurring from the planned treatment and procedures also have been explained to me. These risks include, but are not limited to, the possibility of pain or discomfort during the following treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a transient or permanent temporomandibular joint (TMJ) disorder, opening of or displacement of a tooth or portion thereof into the sinus (a normal cavity situated about upper teeth) or other anatomic location requiring additional surgery to close the opening or recover the tooth structure, temporary or permanent numbness, and allergic reactions.

I understand that during the course of my/the patient's dental treatment something unexpected may arise that may necessitate procedures in addition to or different from those planned. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made concerning the results of the treatment that I/the patient will receive.

All of my questions have been answered to my satisfaction, and I consent to the treatment and procedures prescribed for me/the patient.

I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

I confirm that I have read this form, or it was read to me. I confirm that all blanks were filled in and all inapplicable paragraphs, if any, were crossed out before I signed my agreement/acknowledgement below.

Signature or Guardian Signature (if under 18) **Date**

AUTHORIZATION FOR PAYMENT

I hereby authorize payment directly to **Karen D. Barwick DDS, PA & Associates** of the dental benefits otherwise payable to me.

Signature or Guardian Signature (if under 18) **Date**

AUTHORIZATION FOR INSURANCE CLAIMS

Karen D. Barwick DDS, PA & Associates is authorized to provide an insurance company, claim administrator, and consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract.

I know I have a right to a copy of this authorization upon request and agree that a scan/email/PDF of this authorization is as valid as the original.

Signature or Guardian Signature (if under 18) **Date**

FINANCIAL POLICIES

The Financial Policy in the office of **Karen D. Barwick DDS, PA & Associates** will be as follows:

1. We will require payment on the date of services. If you have dental insurance, please refer to Section #2 below. On certain occasions, we will offer financing or payment plans. These plans, when pre-approved by Dr. Barwick, will be due each and every month. Any payments not received may void your payment or financing plan in our office and payment in full will be immediately due. We now accept CareCredit.
2. We will file your insurance information and a copy of your insurance card. However, your deductible, percentage or co-pay must be paid on the date of services. We will need the employer offering the insurance, the employer's address, plan number and the address, phone and fax numbers of the insurance company. We will also require the insured's full name, address, Social Security number, date of birth and telephone numbers. Failure to supply complete information will require payment in full on the date of services rendered. Once all insurance information is complete, we will attempt to collect from your insurance company for 60 days. If payment is not received within 60 days from the date of service, the balance in full becomes the responsibility of the patient or responsible party. Payment must be received within 15 days following receipt of your statement.
3. All accounts with balances greater than 60 days old will be assessed a monthly finance charge of 1.5%.
4. All accounts with balances older than 90 days may be forwarded to our Collection Agency and/or Small Claims Court for collection. All accounts turned over for collection must be paid in full prior to resumption of treatment.

I have read and agree to all these financial policies.

Signature or Guardian Signature (if under 18) **Date**

Person Responsible for Payments on this Account

Preferred Phone (H) (C) (W)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our 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 at any time at www.karenbarwickdds.com or by contacting our HIPAA Compliance Officer at 150 West Crescent Square Drive, Graham NC 27253; Phone 336.570.3882; Fax 336.570.3583.

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 HIPAA Compliance Officer as listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

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.

Print Name **Signature** **Date**

Personal Representative (if Consent not signed by Patient) **Relationship to Patient**

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