Bertram Dental
1220 West State Hwy 29, Bertram, TX, 78645
(512)-355-2115
www.bertramdentist.com

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Employer:		Occupation:	

Contact Information Address Information

Mobile phone:		Street address:	
Home phone:		City:	
Email:		State:	
		ZIP:	

Emergency Contact Work Information

Full Name:		City:	
Phone number:		State:	
Relation:		ZIP:	

General Health Information

For your safety and to assist us in accurately diagnosing and treating you, please review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS PRIVATE AND CONFIDENTIAL.	
How would you describe your current health?	
Are you currently under the care of a physician? If yes, please provide their name.	
Date of last physical exam and findings (if any):	
What is your preferred Pharmacy? What is their phone number?	
Please choose yes or no:	
Are you aware of any changes in your general health in the last year?	
Have you been hospitalized for illness or surgery in the last 2 years?	
Have you had excessive bleeding that required treatment?	
Is there any history of diabetes in your family?	
Are you required to restrict your activity in any way?	
Are you on a special or restricted diet of any kind?	
Do you smoke/vape?	
If yes, are you interested in quitting?	
Do you use smokeless tobacco?	
If yes, are you interested in quitting?	
Do you snore?	
When you wake in the morning, do you feel rested?	
Do you fatigue easily as the day progresses?	
What is your neck size? (in inches)	
Are you pregnant or planning to become pregnant?	
Are you currently breastfeeding?	
Are you required to pre-med with antibiotics before dental treatment?	
List any medications you are currently taking, please include over the counter as well as vitamins and supplements.	

List All Drug Allergies: Latex Penicillin Codeine, Aspirin, or other pain meds Dental Anesthetics Other	
Indicate which of the following you currently have or have had.	
Heart trouble	
Heart attack or disease *If yes, please state when.*	
Angina	
High blood pressure	
Low blood pressure	
Heart murmur	
Rheumatic fever	
Congenital heart lesions	
Artificial heart valve	
Scarlet fever	
Heart pacemaker	
Heart surgery	
Shortness of breath upon mild exertion	
Require more than 2 pillows to sleep	
Ankles swell	
Epilepsy or seizures	
Frequent headaches	
Fainting or dizzy spells	
Cancer or tumors *If yes, what type?*	
Radiation treatment	
Chemotherapy	
Arthritis/Rheumatism	
Hepatitis	

Liver disease	
Glaucoma	
Anemia	
Artificial joint *Which joint? Please state when you got it.*	
Kidney, bladder trouble	
Thyroid disease	
Emphysema	
Persistent cough	
Tuberculosis	
Asthma *Do you have a rescue inhaler? What medication is it?* *List last date of asthma attack and date of last hospitalization for asthma (if any).*	
Hay fever	
Sinus trouble	
Seasonal Allergies	
Diabetes (Type 1, Type 2, pre-diabetic) *Please list most recent A1C score and date obtained.*	
Frequent thirst and/or urination	
Stroke	
Jaundice	
A.I.D.S	
HIV	
Drug or alcohol addiction	
Blood transfusions *If yes, please state when.*	
Hemophilia	
Ulcers	
Osteoporosis *If yes, list treatment.*	
Bisphosphonate treatment	
Are you a nervous person?	

Psychiatric care	
Unintentional weight loss or gain	
List any additional medical conditions:	
Please share more details about your condition(s)—such as medication names, important dates, or any other information we should know.	
To the best of my knowledge, all the preceding answers are correct and true. If I ever have any changes in my health or if my medications change, I will inform the doctor at or before my next appointment without fail.	

Patient's signature: _____

Date:_____

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DENTAL INSURANCE INFORMATION

Primary Insurance Information

Legal Name	
Date of Birth	
Do you have a dental insurance?	
Patient's relationship to the Insurance Holder	
Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's SSN OR Member ID Number	
Policy Holder's ZIP	
Policy Holder's Employer	
Dental Insurance Company	
Group Number	
Phone number on the back of your insurance card	

Secondary Insurance Information

Do you have a secondary dental insurance?	
That's all! If you would like to add secondary insurance, you need to provide primary insurance first.	
Patient's relationship to the Insurance Holder	
Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's SSN OR Member ID Number	
Policy Holder's ZIP	
Policy Holder's Employer	
Dental Insurance Company	
Group Number	
Phone number on the back of your insurance card	

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DENTAL HISTORY FORM

Basic Information

Please answer the following questions	
Briefly state the reason you are seeking dental care.	
Do you have any discomfort in your mouth now?	
Your previous dentist name and city:	
How long were you a patient?	
Date of last dental visit:	
Were x-rays taken of all of your teeth at that time?	
Do your gums bleed, feel tender or irritated?	
Have you ever had gum treatments or a deep cleaning?	
Are any teeth loose?	
Does anyone in your family have a history of periodontal disease?	
Are your teeth sensitive to hot, cold, or sweets?	
Does anyone in your family have a history of severe decay?	
Do you grind, clench or grit your teeth?	
Do you wear a night guard or splint? If yes, please bring with you at your initial appointment.	
Does your jaw ever click or cause pain on opening or closing?	
Have you ever had any teeth extracted? If yes, were they replaced to prevent shifting of the remaining teeth?	
Do you have any missing teeth you would like to replace?	
Have you ever had a root canal?	
Do you wear dentures? If yes, are you satisfied with your current dentures? How long have you had them?	

Have you ever experienced any growths or sore spots in your mouth?	
Do you floss your teeth?	
Do you like the way your teeth look?	
Are you happy with the color of your teeth?	
Have you ever worn braces or Invisalign?	
Would you like your teeth to be straighter?	
Do you have spaces between your teeth you would like closed?	
If you could change anything about your smile, would you?	
Has anyone ever told you that you stop breathing in the night?	
Do you awake refreshed in the morning?	
Have you ever had a sleep study?	
Have you ever or do you now use a CPAP machine?	
Do you currently wear an appliance? If yes, please bring with you at your initial appointment.	
On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment?	

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FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

Thank you for choosing Bertram Dental as your dental care provider. Our office is committed to providing you with the best possible care. The following statement of our Financial Policy and an Assignment of Benefits. Thank you for your time in reading and understanding this important document.

Regarding Payment

We accept the following forms of payment: Cash, Check, Money Order, Visa, MasterCard, Discover, American Express, and CareCredit. Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor or the billing receptionist. We do charge a 2.6% service fee on all credit card transactions. Checks that are returned to our office from your finan-cial institution are subject to a $35.00 return check fee.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract; however, in most cases as a courtesy to our patients we will file your insurance claim. In the event we do accept assignment of benefits from your insurance company and your insurance company has not paid your account in full within 60 days, the balance then becomes your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services. Your insurance company may only pay for selected treatment or they may not cover any of the treatment provided to you. You are responsible for payment in the event your insurance company does not cover the complete cost of treatment provided to you.

Your complete insurance information must be present at the time services are provided. Insurance claims cannot be backdated. We will do our best to verify your insurance benefits and provide you with an accurate estimate of your cost of treatment. However, please understand that this is simply an estimate and may change once final payment is received from your Insurance company. As a courtesy we will file your insurance claim(s) with one insurance company. All insurance copays and deductibles must be paid at the time of service.

Assignment of Benefits

I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Bertram Dental for dental services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by my insurance.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly at 512-355-2115 for assistance in the management of your account. Please let us know if you have any questions or concerns.

Please remember that you are fully responsible for all fees charged by this office regardless of your insurance coverage.

I have read the Financial Policy and Assignment of Benefits. I understand and agree to the Financial Policy and Assignment of Benefits.

Printed name of Patient or Responsible Party:_____

Signature of Patient or Responsible Party:_____

Date:_____

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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 to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by Federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR IMPLIED CONSENT

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e,g,, a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services, This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities, For example, obtaining approval for procedures may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this office, These activities may include, but are not limited to, quality assessment activities, employee review activities and staff training.

For example, we may disclose your protected health information to interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses, We may also call you by name in the reception area when your doctor is ready to see you, We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "Business Associates" that perform various activities (e,g,, billing, transcription services for the practice), Whenever an arrangement between our office and a Business Associate involves the use or disclosure of your protected health information, we will have a written agreement with that Business Associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you, We may also use and disclose your protected health information for other internal marketing activities, For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you, You may request that these materials not be sent to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT MAY BE MADE WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

For example, with your written, signed authorization, we may use your demographic information and the dates that you received treatment from our office, as necessary, in order to contact you for fundraising activities supported by our office.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable Federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or

administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Workers' Compensation: We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

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 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

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. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please ask your doctor if you have questions about access to your medical record.

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 healthcare 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 be in writing and state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to a staff member in our office. The staff member will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff member provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

You may have the right to have your doctor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please ask your doctor if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limits.

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 electronically.

C. Complaints

You may complain to us, to the Texas Attorney General's Office, or 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 Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer in writing at our office address. Our website may offer additional information about the complaint process.

This notice was published and becomes effective on May 27, 2025.

Contact Office:
Bertram Dental
1220 West State Hwy 29
Bertram, TX 78645
512-355-2115

Patient’s Signature: _____ Date: _____

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HIPAA AND PROTECTED HEALTH INFORMATION DISCLOSURE CONSENT

NOTICE OF PRIVACY PRACTICES
Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION
Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

COMMUNICATIONS

PHONE
With this consent, Bertram Dental may call my home or other alternative location and leave a message on voicemail, speak directly to family members answering my phone, or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

Initials: _____

TEXT MESSAGE
With this consent, Bertram Dental may text my home or other alternative location in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Bertram Dental will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Bertram Dental cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

Initials: _____

MAIL
With this consent, Bertram Dental may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminder cards and patient statements

EMAIL
With this consent, Bertram Dental may email to my home email address or other alternative location any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminder cards and patient statements. ansmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Bertram Dental will use reasonable means to protect the security and confidentiality of email information sent and received. However, Bertram Dental cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

Initials: _____

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION You may request a restriction on the use or disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

REVOCATION OF CONSENT
You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication between Bertram Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Bertram Dental.

By my signature below I give permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date_____Time _____
Print Patient's Full Name_____

Witness Signature

Date_____ Time_____