Richard M. Berg, DDS, FAGD
54 Copperfield Circle
Lititz, PA 17543
(717) 627-3113

Date: _____ Patient's Name: _____
Last First Middle

Address:_____
Street City State Zip Code

Home Ph. # ( ) _____ Work Ph. # ( ) _____ Soc. Sec. # _____- ___-_____ Drivers Lic. # _____

Birthdate ____/___/____ Sex M F If patient is a minor, give parent's/guardian's name_____

Name of nearest relative not living with you: _____ Relationship: _____

Complete Address _____ Ph. # ( ) _____

Emergency Contact _____ Ph. # ( ) _____

Responsible Party Information

Name_____
Last First Middle Marital Status

Soc. Sec.# ___ - ____ - _____ Birthdate _____/_____/_____ Relationship to Patient _____

Mailing Address _____ How long at this address? _____
Street City State Zip Code

Home Ph. # ( ) _____ Work Ph. # ( ) _____ Email Address: _____

Previous Address (if less than 3 years) _____

Employer_____ Occupation _____ No. Years Employed_____

Employer Address_____

Spouse's Name _____ Birthdate ____/___/____ Work Ph. # ( ) _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. #_____

Place of Employment_____ Ph. # ( ) _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # ( ) _____

Consent

1. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. I also authorize doctor to perform all recommended treatment mutually agreed upon and to use the appropriate medication and/or therapy indicated for such treatment.
2. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due at the time services are rendered unless prior arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a $4.00 monthly late charge may be added to my account in addition to any collection charges.
3. I understand that credit bureau reports may be obtained and authorize this office to obtain same, at their discretion.
4. I understand that it is my responsibility to advise this office of any changes in the information obtained on this form..
5. I understand that the information on this form will be held in strict confidence.
6. I authorize the release of personal/dental information to any referral Dr. and/or insurance company. This includes (but is not limited to) treatment plans, radiographs, periodontal information, ADA codes and charges.

_____ _____ _____
Signature of Patient or Responsible Party Print Patient Name Date