

# The Art of Dentistry



**Stephen J. Gershberg, D.M.D.**

## New Guest Checklist

We have designed our new guest checklist to make your first encounter, at our office, **an exciting and rewarding experience not only for you, our guest, but for ourselves as well.** Please take a few moments to review the list and gather the needed information.

- Please **read** Dr Gershberg's bio and New Guest forms.
- ★ • Please **fill out your forms** and **bring them with you. Failure to do so may result in the need to reschedule your appointment!**
- Please arrive **10 minutes early** for your reservation
- Please bring any applicable insurance cards or information needed to assist our office **in helping you** receive your **maximum reimbursement** possible.
- Please bring a written list of all **medications** that you are currently taking, along with the **dosages**.
- Last but not least, please bring a **list of any questions or concerns** that will help the doctor personalize your treatment.

If you have any questions, please feel free to call me at the office or e-mail at: [patti@drgershberg.com](mailto:patti@drgershberg.com) . My business card is enclosed and I will be happy to answer any questions or concerns that you may have. We thank you in advance.

Sincerely,

Patti Staniorski  
Practice Coordinator

14 S. Bryn Mawr Ave., Suite 200 Bryn Mawr, PA 19010

Phone: 610-527-6700

Fax: 610-527-6704

[www.DrGershberg.com](http://www.DrGershberg.com)

# Welcome to Dr. Stephen J. Gershberg's Office



We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

**1. Patient Information**

Mr.  Mrs.  Ms.  Dr.  Miss \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Nickname \_\_\_\_\_  
 Last Name First Name Initial

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_

Business # \_\_\_\_\_ ext \_\_\_\_\_ Cell Phone # \_\_\_\_\_ E-mail \_\_\_\_\_

Sex  M  F DOB \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Spouse \_\_\_\_\_ Children \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Person financially responsible for account \_\_\_\_\_ Last Name First Name Initial

Whom may we thank for referring you? \_\_\_\_\_

**2. Primary Dental Insurance**

Subscriber Name \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Subscriber Number \_\_\_\_\_

Name of other dependents covered under this plan \_\_\_\_\_

**3. Secondary Dental Insurance**

Is patient covered by secondary insurance?  yes  No

Subscriber Name \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Subscriber Number \_\_\_\_\_

Name of other dependents covered under this plan \_\_\_\_\_

Please Complete Both Sides

4.

Dental History

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

City/State \_\_\_\_\_

Phone Number \_\_\_\_\_

Date of last dental X-rays \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

1. Bad breath	<input type="checkbox"/> yes	<input type="checkbox"/> no	4. Burning sensation on tongue	<input type="checkbox"/> yes	<input type="checkbox"/> no	15. Mouth breathing	<input type="checkbox"/> yes	<input type="checkbox"/> no
2. Bleeding gums	<input type="checkbox"/> yes	<input type="checkbox"/> no	5. Chew on one side of mouth	<input type="checkbox"/> yes	<input type="checkbox"/> no	16. Orthodontic treatment	<input type="checkbox"/> yes	<input type="checkbox"/> no
3. Blisters on lips or mouth	<input type="checkbox"/> yes	<input type="checkbox"/> no	6. Clicking or popping jaw	<input type="checkbox"/> yes	<input type="checkbox"/> no	17. Pain around ear	<input type="checkbox"/> yes	<input type="checkbox"/> no
			7. Dry mouth	<input type="checkbox"/> yes	<input type="checkbox"/> no	18. Pain while brushing	<input type="checkbox"/> yes	<input type="checkbox"/> no
			8. Fingernail biting	<input type="checkbox"/> yes	<input type="checkbox"/> no	19. Periodontal treatment	<input type="checkbox"/> yes	<input type="checkbox"/> no
			9. Food collection between the teeth	<input type="checkbox"/> yes	<input type="checkbox"/> no	20. Sensitivity to cold	<input type="checkbox"/> yes	<input type="checkbox"/> no
			10. Grinding teeth	<input type="checkbox"/> yes	<input type="checkbox"/> no	21. Sensitivity to heat	<input type="checkbox"/> yes	<input type="checkbox"/> no
			11. Gums swollen or tender	<input type="checkbox"/> yes	<input type="checkbox"/> no	22. Sensitivity to sweets	<input type="checkbox"/> yes	<input type="checkbox"/> no
			12. Jaw pain or tiredness	<input type="checkbox"/> yes	<input type="checkbox"/> no	23. Sensitivity when biting	<input type="checkbox"/> yes	<input type="checkbox"/> no
			13. Lip or cheek biting	<input type="checkbox"/> yes	<input type="checkbox"/> no	24. Sores or growths in your mouth	<input type="checkbox"/> yes	<input type="checkbox"/> no
			14. Loose teeth or broken fillings	<input type="checkbox"/> yes	<input type="checkbox"/> no	25. Tobacco use	<input type="checkbox"/> yes	<input type="checkbox"/> no
						26. Alcohol use	<input type="checkbox"/> yes	<input type="checkbox"/> no
						27. Ever involved with Dental/Medical legal activity	<input type="checkbox"/> yes	<input type="checkbox"/> no
						28. How often do you floss?	_____	
						29. How often do you brush?	_____	

Doctor's Notes: \_\_\_\_\_

5.

Health History

Physician's Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Date of last visit \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

1. AIDS	<input type="checkbox"/> yes	<input type="checkbox"/> no	18. Endocarditis	<input type="checkbox"/> yes	<input type="checkbox"/> no	41. Radiation Treatment	<input type="checkbox"/> yes	<input type="checkbox"/> no
2. Alcohol/Drug Addiction	<input type="checkbox"/> yes	<input type="checkbox"/> no	19. Epilepsy/Seizures	<input type="checkbox"/> yes	<input type="checkbox"/> no	42. Respiratory Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no
3. Anemia	<input type="checkbox"/> yes	<input type="checkbox"/> no	20. Fainting or dizziness	<input type="checkbox"/> yes	<input type="checkbox"/> no	43. Rheumatic Fever	<input type="checkbox"/> yes	<input type="checkbox"/> no
4. Arthritis, Rheumatism	<input type="checkbox"/> yes	<input type="checkbox"/> no	21. Glaucoma	<input type="checkbox"/> yes	<input type="checkbox"/> no	44. Shortness of Breath	<input type="checkbox"/> yes	<input type="checkbox"/> no
5. Artificial Heart Valves	<input type="checkbox"/> yes	<input type="checkbox"/> no	22. Headaches	<input type="checkbox"/> yes	<input type="checkbox"/> no	45. Sinus Trouble	<input type="checkbox"/> yes	<input type="checkbox"/> no
6. Artificial Joints	<input type="checkbox"/> yes	<input type="checkbox"/> no	23. Heart Attack	<input type="checkbox"/> yes	<input type="checkbox"/> no	46. Special Diet	<input type="checkbox"/> yes	<input type="checkbox"/> no
7. Asthma	<input type="checkbox"/> yes	<input type="checkbox"/> no	24. Heart Murmur	<input type="checkbox"/> yes	<input type="checkbox"/> no	47. Stomach, Intestinal Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no
8. Back Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	25. Heart Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	48. Stroke	<input type="checkbox"/> yes	<input type="checkbox"/> no
9. Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no	26. Hepatitis Type _____	<input type="checkbox"/> yes	<input type="checkbox"/> no	49. Surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
10. Blood Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no	27. Herpes	<input type="checkbox"/> yes	<input type="checkbox"/> no	50. Swelling of Feet or Ankles	<input type="checkbox"/> yes	<input type="checkbox"/> no
11. Cancer	<input type="checkbox"/> yes	<input type="checkbox"/> no	28. High Blood Pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	51. Swollen Neck Glands	<input type="checkbox"/> yes	<input type="checkbox"/> no
12. Chemotherapy	<input type="checkbox"/> yes	<input type="checkbox"/> no	29. Hip/Joint Replacement	<input type="checkbox"/> yes	<input type="checkbox"/> no	52. Thyroid Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no
13. Circulatory Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	30. HIV Positive	<input type="checkbox"/> yes	<input type="checkbox"/> no	53. Tonsillitis	<input type="checkbox"/> yes	<input type="checkbox"/> no
14. Congenital Heart Lesions	<input type="checkbox"/> yes	<input type="checkbox"/> no	31. Injury to head/neck	<input type="checkbox"/> yes	<input type="checkbox"/> no	54. Tuberculosis	<input type="checkbox"/> yes	<input type="checkbox"/> no
15. Cough, persistent or bloody	<input type="checkbox"/> yes	<input type="checkbox"/> no	32. Jaundice	<input type="checkbox"/> yes	<input type="checkbox"/> no	55. Tumor or growth on head or neck	<input type="checkbox"/> yes	<input type="checkbox"/> no
16. Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no	33. Kidney Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no	56. Ulcer	<input type="checkbox"/> yes	<input type="checkbox"/> no
17. Emphysema	<input type="checkbox"/> yes	<input type="checkbox"/> no	34. Liver Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no	57. Venereal Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no
			35. Low Blood Pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	58. Weight Loss, unexplained	<input type="checkbox"/> yes	<input type="checkbox"/> no
			36. Mitral Valve Prolapse	<input type="checkbox"/> yes	<input type="checkbox"/> no	59. Women:		
			37. Nervous Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	Are you pregnant?	<input type="checkbox"/> yes	<input type="checkbox"/> no
			38. Osteoporosis	<input type="checkbox"/> yes	<input type="checkbox"/> no	Due date _____		
			39. Pacemaker	<input type="checkbox"/> yes	<input type="checkbox"/> no	Are you nursing?	<input type="checkbox"/> yes	<input type="checkbox"/> no
			40. Psychiatric Care	<input type="checkbox"/> yes	<input type="checkbox"/> no	60. Other _____		

Doctor's Notes: \_\_\_\_\_

Medications

Allergies  yes  no

Have you ever had to medicate prior to dental visits?  yes  no

Have you ever taken medication to prevent osteoporosis?  yes  no

List medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

Latex  Penicillin

Local Anesthetic  Other \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

Note: A change in your health status should be reported to the office at the earliest possible time.

6.

Authorization

To the best of my knowledge all questions have been answered correctly. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners. I give Dr. Stephen J. Gershberg permission to use my photos and models for laboratory communications, educational, and/or marketing purposes.

Person completing the form: Signature \_\_\_\_\_

Date \_\_\_\_\_ Print Name \_\_\_\_\_

If other than patient, indicate relationship: \_\_\_\_\_

If patient is a minor I give consent for treatment necessary.

Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Payment is due in full at time of treatment unless prior arrangements have been approved.



**Stephen J. Gershberg, D.M.D.**

**New Patient Questionnaire**

1. Are you dissatisfied with your teeth in any way? For example: color, shape, spaces, etc. \_\_\_\_\_
2. Have you thought about bleaching your teeth? \_\_\_\_\_
3. Do you have any missing teeth? \_\_\_\_\_
4. Does food constantly get stuck between certain teeth?  
\_\_\_\_\_
5. Do you grind or clench your teeth? \_\_\_\_\_
6. Do you have any fillings/bondings that show in your front teeth?  
\_\_\_\_\_
7. Have you ever thought about Invisalign-invisible braces? \_\_\_\_\_
8. Do you have any old mercury (silver) fillings that you would like replaced with tooth colored fillings? \_\_\_\_\_
9. Who can we thank for your referral? \_\_\_\_\_



**Stephen J. Gershberg, D.M.D.**

**Office Financial Policy**

We are committed to providing you with the best possible care, while making your dental treatment affordable to all of our patients. In order to achieve these goals and to keep the rising costs of dentistry to a minimum, we ask for your assistance and understanding of our policy.

1. **Payment for services is due at the time services are rendered, by you, the patient or guardian, unless prior payment arrangements have been made and approved by our financial coordinator in advance of the appointment. We offer the following:**
  - **Cash or Check**
  - **Visa, MasterCard, or Discover**
  - **Debit bank cards**
  - **Care Credit Financing ([www.carecredit.com](http://www.carecredit.com))**
2. **If you have dental insurance, we will be happy to process your insurance claim, for your maximum reimbursement, once your balance has been paid in full. While the filing of claim forms is a courtesy that we extend to our patients, all charges are your responsibility at the time of treatment.**
3. **Returned checks and balances over 30 days are subject to any resulting bank fees that we incur and interest charges of 1.5% per month.**
4. **In the event of a broken appointment without 24 hours notice, there may be a charge of \$50.00 per scheduled appointment with our hygienist and \$100.00 per scheduled appointment with Dr Gershberg, except if the Large Case Refund Policy has already been signed by you, the patient or guardian.**

If you have any questions regarding this policy or your insurance, please do not hesitate to ask.

Patient/Guardian Signature: \_\_\_\_\_ date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ date: \_\_\_\_\_

# Notice of Privacy Practices Stephen J. Gershberg, D.M.D., P.C.

## Acknowledgement of Receipt of Notice of Privacy Practices

**\*\*You May Refuse To Sign This Acknowledgement\*\***

**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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### 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:  
(please circle one)

1. Individual refused to sign
2. Communications barrier prohibited obtaining the acknowledgement
3. An emergency situation prevented us from obtaining the acknowledgement
4. Other (Please Specify) \_\_\_\_\_

# The Art of Dentistry



**Stephen J. Gershberg, D.M.D.**

## **And Finally, A Bargain We Would Like to Make with You**

Here is what we feel we owe to each other. It is what we like our relationship, with you, to be built upon. If you have any concerns at all with this, we are happy to discuss with you what you feel would be fair.

- **We** must listen to you when you talk.
- **We** must tell you in advance, your dental options and the cost of any treatment.
- **We** must provide our very best treatment for you and your situation.
- **We** will do our absolute best to keep on time because we know everyone hates to be kept waiting. We do ask for your compassion in the event of another patient's dental emergency.
- **We** must apologize and make amends if we don't perform as we promise, and you can be the judge of our performance.

We ask, in return, the following:

- **You** must listen when we talk.
- **You** should bring to our attention if something upsets you. This way, we have the opportunity to apologize and make it right!
- **You** must confirm your appointments with us via phone or e-mail.
- **You** must be on time for your reserved appointments so that we do not inconvenience the next patient who will then have to wait.
- **You** will pay your treatment fees as per our written arrangements. If your financial situation should change during treatment, please bring it to our attention immediately so that we can discuss it.
- **If you** know of anyone whom you feel would benefit from the dental services that we provide, we ask that you refer them to our practice. In this way, we can continue to grow and be here for you, when you need us.

14 S. Bryn Mawr Ave., Suite 200 Bryn Mawr, PA 19010

Phone: 610-789-1001

Fax: 610-789-5078

[www.DrGershberg.com](http://www.DrGershberg.com)