



Patient Information

Legal Name: _____ Preferred Name: _____

Birth Date: _____ SSN: _____ Male or Female

Email: _____

Phone Number: _____ Home: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Previous/Current Dentist: _____ Last Visit: _____

Referral: _____

If the responsible party is different from the patient.

Legal Name: _____

Birth Date: _____ SSN: _____ Male or Female

Email: _____

Phone Number: _____ Home: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

Insurance Information

Primary Name: _____ DOB: _____

Insurance Company: _____ ID # _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Appointment Confirmation Policy

We strive to achieve an experience where the patient and the facility both have a memorable experience. However, this can only be achieved if both parties work together in harmony. We completely understand that when you make an appointment, you made it for a reason. However, we also know that there are always going to be emergencies. Therefore, we require 30 seconds of your time to go ahead and confirm your appointment within **24 hours** before your appointment by simply replying to our phone calls, text messages, or emails.

Over the past few years, we have had many times when patients want a certain time and date, but unfortunately, we are unable to give it to them because it was not available. If we want everyone to get what they please, we need to be efficient. Therefore, we require a **24-hour cancellation notice** from all our patients. By simply calling us, replying to our text messages, or emailing us, letting us know that you are unable to make your appointment, we can try our best to get someone else in for the time you could not. If we do not receive a **24-hour cancellation notice**, there will be a **\$25.00 cancellation fee** for general dentistry that will be automatically added to your account. For implant surgery cases, there will be a \$1500 nonrefundable fee applied to your account. We want to be a practice where people communicate with each other.

After many attempts to ask you to confirm your appointment, we will have to remove you from the schedule if we do not hear from you. If you attend your appointment without confirmation, it will be treated as a **“work-in”** if the schedule allows. **Please prepare for a longer wait time.** Although we hope that you do not miss an appointment or cancel after the 24-hour cancellation notice, we do have a **2-time policy**. If you miss or cancel after the **24-hour 2 times**, we will have to terminate you as a patient. Time is valuable to both you and our office, and we understand that complications may occur. We want your experience to be efficient and exceptional, but we can only achieve this if we work together.

Sincerely, Dr. Patel and team

Signature: _____

Date: _____

Our Office and Financial Policies

Thank you for choosing us as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions, please feel free to ask any staff member for more information.

Appointments

Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you must change an appointment, a **24-hour notice** is expected. A fee maybe applied for appointments missed without notice. Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.

Insurance

A courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, we do require you to pay your deductible and/or "estimated patient portion" at the time of service. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. If you have dental insurance, you must provide us with your dental insurance card. We must be able to verify coverage before we can accept assignment of benefits. Please not that dental insurance plans are different from your medical insurance. Each plan has different yearly deductibles and benefits. Most insurance plans will pay, at most, 80% of basic procedures and 50% of major procedures. When possible, we will submit a dental pre-estimate to your insurance company for review. This will allow you to know the exact amount that the insurance company will pay. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that I am responsible for reading and understanding my dental insurance benefits. _____

Usual and Customary Rates

Please be aware that some of our services may be "non-covered", subject to an insurance company's arbitrary determination of usual and customary rates or have time limitations imposed by the insurance company. Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive. You are responsible for any balance left unpaid by your insurance company. The adult accompanying a minor is responsible for full payment.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, CREDIT AND DEBIT CARDS.

Thank you for understanding our guidelines. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above office and financial policies.

X _____

Signature of patient or responsibility party

Date

Have you ever taken or currently taking any of the following Bisphosphonate?

Pamidronate (APD, Aredia), Neridronate (Nerixia), Olpadronate, Alendronate (Fosamox), Ibandronate (Boniva), Risedronate (Actonal), Zoledronate (Zometa, Aclasta).

IV Bisphosphonates? _____ If yes, list name of medications and date:

Oral Bisphosphonates? _____ If yes, list name of medications and date:

I have reviewed the above information to the best of my knowledge.

Patient Signature:

Date: _____

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW DENTAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices. This notice describes how your dental information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to request and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request disclosures of your information.
5. The right to a paper copy of this Notice.

PLEASE LIST THE NAMES OF ALL THE PEOPLE (SPOUSE, PARENTS, GRANDPARENTS, ETC..) YOU HAVE AUTHORIZED TO RELEASE OF YOUR DENTAL INFORMATION, INCLUDING COPIES OF YOUR RECORDS NEEDED:

Name: _____

Relation: _____

Name: _____

Relation: _____