Preston Bend Dental

Anita Naik Madhav D.D.S.

Date:________________________ Referral Source:________________________

PATIENT INFORMATION

First Name:__________________ Last Name:__________________ Preferred: __________________

SS#:__________________ Birth Date:__________________ Sex: Male / Female

Patient's Home #:__________________ Patient's Work #:__________________

Patient's Cell #: __________________ Any Other #:__________________

Email Address: ____

Employer:__________________ Occupation:__________________

Address:____

(street) (city, state) (zip)

Emergency Contact Name: __________________ Relationship to you:__________________

Emergency Contact Phone #: ____

DENTAL HISTORY

Reason for today's visit:____

Former Dentist: __________________ Date of last dental care: __________________

How often do you brush?__________________ Floss? __________________

Do you use a manual or motorized tooth brush? __________________ What brand?__________________

Are you happy with your smile? ____

Please check if you have experienced **ANY** *of the following (please mark* **ALL** *responses)*

Bad Breath	☐ YES	☐ NO	Heat Sensitivity	☐ YES	☐ NO
Biting Sensitivity	☐ YES	☐ NO	Loose Teeth	☐ YES	☐ NO
Bleeding Gums	☐ YES	☐ NO	Jaw Joint Pain	☐ YES	☐ NO
Broken Fillings	☐ YES	☐ NO	Orthodontic Treatment	☐ YES	☐ NO
Cold Sensitivity	☐ YES	☐ NO	Periodontal Treatment	☐ YES	☐ NO
Food Collection	☐ YES	☐ NO	Sores/Growths in Mouth	☐ YES	☐ NO
Grinding Teeth	☐ YES	☐ NO	Sweet Sensitivity	☐ YES	☐ NO

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give a copy of the office notice of privacy practices and make a good faith effort to obtain an acknowledgement of receipt of same. You may refuse to sign below. By signing below, I confirm that I have read/received a copy of the notice of privacy practices.

Print Patient Name: ____

Patient Signature: ____ **Date:** __________________

MEDICAL HISTORY

Physician's Name:____

Phone #:______________________ Date of Last Physician Visit: _______________

Please check if you have experienced **ANY** *of the following (please mark* **ALL** *responses)*

Condition		
Abnormal Bleeding	☐ YES	☐ NO
AIDS (HIV+)	☐ YES	☐ NO
Alcohol/Drug Abuse	☐ YES	☐ NO
Allergies	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Artificial Joints	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Artificial Heart Valves	☐ YES	☐ NO
Back Problems	☐ YES	☐ NO
Blood Disease	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Chemotherapy	☐ YES	☐ NO
Cortisone/Steroid Treatment	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO
Heart Problems	☐ YES	☐ NO
Hepatitis/Liver Disease	☐ YES	☐ NO
Herpes/Fever Blisters	☐ YES	☐ NO
Chest Pains	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO

Condition		
Take Aspirin/Blood Thinner	☐ YES	☐ NO
Undergone Cancer Treatment	☐ YES	☐ NO
Have Taken Bisphosphanates	☐ YES	☐ NO
Have Taken Fosamax	☐ YES	☐ NO

Condition		
Epilepsy	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Kidney/Bladder Disease	☐ YES	☐ NO
Pace Maker	☐ YES	☐ NO
Psychiatric Care	☐ YES	☐ NO
Radiation Treatment	☐ YES	☐ NO
Rheumatic Fever	☐ YES	☐ NO
Shortness of breath	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Thyroid Problems	☐ YES	☐ NO
Tobacco Habit	☐ YES	☐ NO
Tonsillitis	☐ YES	☐ NO
Tuberculosis/Emphysema	☐ YES	☐ NO
Mitral Valve Prolapse	☐ YES	☐ NO
Ulcer	☐ YES	☐ NO

Women Only:

Condition		
Currently On Birth Control Pills	☐ YES	☐ NO
Currently Nursing	☐ YES	☐ NO
Currently Pregnant	☐ YES	☐ NO

***Women of Childbearing age**:*
Please note that there may be a reduced effectiveness of oral steroid contraceptives during antibiotic therapy. Therefore, we advise you to use additional/alternate forms of contraception during antibiotic use.

Are you taking any medications? ☐ YES ☐ NO

Please list any medications you are taking:

____

____

Are you **ALLERGIC** to any medication, anesthetic, or materials such as zippers, costume jewelry, latex gloves, etc.?

☐ YES ☐ NO If yes, please explain:____

____

Do you have any disease or condition or anything about your health that we have not covered and that we may need to know?

☐ YES ☐ NO If yes, please explain:____

____

Dr. Madhav Initials:____________ Date: _________

ADMINISTRATIVE POLICY

- In order to provide true personalized dental care, **we are NOT a network provider with any insurance policy**. That means we do not sign contracts with insurance companies to treat you according to what benefits them financially. Only you, the patient, in consultation with the doctor, will decide what dental services are rendered.
- Insurance Policies are a contract between you and the insurance company. The final responsibility for payment rests with you, the consumer. As a courtesy, we file all insurance claims on behalf of our patients.
- Payment for services is due at the time services are rendered. For services that qualify, we can arrange for low monthly payments through a third party financing company. We accept cash, checks, and all major credit cards. The bank charges us a service fee for all returned checks which we will pass on to you if your check is dishonored.
- If after 60 days from the date of service a balance has not been paid, collection efforts may commence.
- Out of courtesy to other patients and the office staff, please give at least 48 hours notice for an appointment cancellation. We reserve the right to charge $100 for cancellations with less than 48 hours notice.
- The parent or guardian who brings the child in for their visit is responsible for payment irrespective of what a divorce decree may state.
- Before commencing any treatment, you will be provided a written treatment plan with all of the recommended treatment and associated fees.
- It is the responsibility of you, the patient, to inform this office of any changes in your medical status or contact information.

INSURANCE OPTIONS

*We offer **TWO** payment Options. Please tell us which payment method you prefer by signing below:*

Option One

To avoid monthly statements or bills, our patients have the option to pay for their entire visit **IN FULL** on the date of service. As a courtesy, we file all insurance claims for our patients. If you would like Option One, please sign below:

Option One: Patient Signature:____ Date:_______________________

Option Two

Our patients have the option to pay only the **ESTIMATED** patient portion on the day of your appointment. Should your insurance pay any less than we have estimated, we will send you a statement in the mail. Our patients who choose this option are expected to pay any remaining balance. If you would like Option Two, please sign below:

Option Two: Patient Signature:____ Date:_______________________

ACKNOWLEDGEMENT

By signing below, I acknowledge:

I have read, understand and accept the above Administrative Policy.

I authorize Dr. Madhav and staff to release any information concerning my case to my insurance company if applicable.

I authorize Dr. Madhav and staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Print Patient Name: ____

Patient Signature: ____ **Date:** _______________________

Office use:

___Emergency situation prevented obtaining signature

___Unable to communicate with patient

Reviewed by:

____