

Neighborhood Pediatric and Adult Dentistry

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

Patient Information

Date _____
Name _____ SSN# _____
Address _____
City _____ State _____ Zip _____ Sex Male Female
HM# _____ Work# _____ Cell# _____
Age _____ Date of Birth _____ Marital Status Single Married Widowed Separated Divorced
(If Patient is Minor) Who accompanying patient today? _____
Email Address _____
Patient's Employer/School/College _____
Whom may we thank for referring you? _____
In case of emergency contact _____ Phone _____

Dental Insurance Information

Insurance Company Name _____ ID# _____ Group# _____
Insured's Name _____ Insured's SSN# _____ DOB _____
Address _____
City _____ State _____ Zip _____ HM#: _____ Cell# _____
Insurance Co. Phone # _____ Insured's Employer _____
Marital Status: Single Married Widowed Separated Divorced
Relationship to Patient: Self Spouse Parent Other _____
Do you have legal custody of the child/person Yes No N/A
Do you have dual dental insurance? No Yes If Yes: Insurance Company _____

****** It is important for you to understand that your dental insurance coverage is an agreement between you and your insurance company and your doctor's bill for the services provided to you is an agreement between you and your doctor ******

***** We DO NOT bill for secondary insurance unless the patients secondary coverage is Medicaid or any state funded insurance. It becomes the responsibility of the patient to submit to all other secondary insurance. Patients are responsible for all balances following primary insurance payment *****

Dental History

What is reason for today's Visit? _____
Former Dentist _____ Phone _____
Date of last dental visit _____ How often do you brush? _____ Floss? _____
Check if you have the following:
 Bad Breathe Food Collection between Teeth Periodontal Treatment Sensitive to Sweets
 Bleeding Gums Grinding Teeth Sensitive to Hot Sensitive to Cold Sensitive to Biting
 Loose Teeth Clicking or Popping Jaw Broken Fillings Sore or Growths in Mouth
Any history of Brace? _____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Yes No

Physician's Name _____ Phone# _____ Date of last visit: _____

Have you had any serious illness or conditions? No Yes: Explain: _____

Are you currently under physician care? No Yes: If Yes, Explain: _____

Have you had any blood transfusions? No Yes: If Yes, Dates: _____

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth Control? Yes No

Medical History

<input type="checkbox"/> Yes <input type="checkbox"/> No Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Neurological	<input type="checkbox"/> Yes <input type="checkbox"/> No Mental Retardation
<input type="checkbox"/> Yes <input type="checkbox"/> No Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Orthopedic Problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No Exposed to AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No Reflux or Gerd
<input type="checkbox"/> Yes <input type="checkbox"/> No Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever
<input type="checkbox"/> Yes <input type="checkbox"/> No Blood Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No Gastrointestinal Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Scoliosis
<input type="checkbox"/> Yes <input type="checkbox"/> No Brain Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No Sexually Transmitted
<input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis or Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No HIV +	<input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell Anemia
<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer, Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease/Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No Skin Problem
<input type="checkbox"/> Yes <input type="checkbox"/> No Cleft lip/Palate	<input type="checkbox"/> Yes <input type="checkbox"/> No Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No Speech Problem
<input type="checkbox"/> Yes <input type="checkbox"/> No Convulsion/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis
<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney/Bladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Use of Tobacco
<input type="checkbox"/> Yes <input type="checkbox"/> No Drug or Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No Leukemia	
<input type="checkbox"/> Yes <input type="checkbox"/> No Endocrine Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No Osteopenia/Osteoporosis	Other: _____

Allergies

<input type="checkbox"/> Yes <input type="checkbox"/> No Antibiotics	If so, which one? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No Lidocaine
<input type="checkbox"/> Yes <input type="checkbox"/> No Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No Novocain
<input type="checkbox"/> Yes <input type="checkbox"/> No Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No Other _____

Current Medications taking: _____

Is there anything else we should know about you or your family? _____

ACKNOWLEDGEMENT OF PATIENT INFORMATION/ AUTHORIZATION FOR INITIAL EVALUATION

The information I have given is correct to the best of my knowledge. I understand that all information is confidential, and it is my responsibility to inform this office of any changes in myself or my child's medical status. I authorize the dental staff to perform the necessary dental services to myself or my child for an initial evaluation. Any other dental services required will be explained and authorize by me after the initial visit.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

******* As a courtesy, we verify your insurance benefit prior to the appointment. The response from insurance is NOT an authorization for, nor a guarantee of, eligibility, benefits, or payment. Actual benefits are determined only when the claim is received by the insurance *******

I certify that myself and/or I my child is covered by insurance and assign directly to Dr. Kiran Kamdar/ Neighborhood Pediatric & Adult Dentistry all insurance benefits, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not covered by dental insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Payment is expected at time of treatment. Patients with insurance may pay only their portion, including deductible. However, it is the patient's responsibility to see that the insurance company makes prompt payment. Any insurance balance over 30 days is due and payable by the parent, legal guardian or responsible party. In the event that my account becomes delinquent and/or is turned over to a third party for collection, I am responsible for any and all billing fees, finance charges, legal fees, and collection cost.

CONSENT FOR ELECTRONIC COMMUNICATIONS

When necessary, this practice emails dental x-rays, records, and/or dental photographs to your insurance company and dental specialists or laboratory technicians involved in your treatment. My signature below gives this practice permission to email my dental records when necessary without encrypted.

NO SHOW / MISSED APPOINTMENT / LATE ARRIVAL POLICY

It is the policy of this office for patients to reschedule or cancel appointments **48 hours** in advance or there will be a **\$45.00 to \$100.00** charge for late cancellation. Patients are expected to arrive on time for their appointments. Appointments are made to your convenience. Please understand your responsibility in regards to the policies listed.

HIPAA

I have review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of Privacy Practices.

Signature: _____ Date: _____ Doctor's Signature: _____ Date: _____