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

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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

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

Allergies

☐Yes☐No Antibiotics	If so, which one? _____
☐Yes☐No Aspirin	☐Yes☐No Lidocaine
☐Yes☐No Codeine	☐Yes☐No Novocain
☐Yes☐No Latex	☐Yes☐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: _____