DENTALWAYS

Better Smile • Better Health • Better Life

Dr. Denesh Khullar - Awarded as one of America's Top Dentists

Welcome to our office, my team and I would like to get to know you better!

Date ___________Name ____Date of Birth ________________Marital Status _________

Home Address____Zip_____________SS#______________________

Cell #____________________Home #____________________**E-mail** ____

Occupation ________________________Employer ______________________________________Employer #________________________

Spouse Name ______________________________Spouse Occupation _____________________Spouse's Employer ___________________

Spouse Employer # ____________________Emergency Contact______________________ Emergency #____________________________

Whom may we thank for referring you or how did you find out about us? (Circle One)

Friend/Family **Yellow Page Ad** **Internet Search** **Insurance Listing** **Other**

If other or friend/family please specify: ____ If Internet please specify: _____________

Person financially responsible for this account ____

Do you have a dental benefit plan? ______ if yes, carrier ____

MEDICAL HISTORY

(Circle all that apply currently on in your past medical history)

Anemia	**Angina**	**Arrhythmias**	**Arthritis/Rheumatism**	**Artificial Heart Valve**	**Botox**
Artificial Joints	**Asthma**	**Blood Thinners**	**Blood Transfusion**	**Bypass Surgery/Stents**	**Filler**
Cancer	**Cold Sores**	**COPD**	**Defibrillator**	**Dialysis Shunt**	
Diabetes	**Emphysema**	**Endocarditis**	**Epilepsy/Seizures**	**Excessive Bleeding**	
Fainting/Dizziness	**Glaucoma**	**Healing Complication**	**Heart Disease**	**Heart Murmur**	
Hemophilia	**Hepatitis A**	**Hepatitis B or C**	**Herpes**	**High Blood Pressure**	
HIV/AIDS	**Hives/Rashes**	**Hyperthyroidism**	**Hypothyroidism**	**Irregular Heartbeat**	
Kidney Disease	**Latex Allergy**	**Liver Disease**	**Mitral Valve Prolapse**	**Nervous Disorder**	
Organ Transplant	**Osteoporosis**	**Pacemaker**	**Pregnant / Past**	**Psychiatric Care**	
Radiation or Chemotherapy/Tumors		**Respiratory Disease**	**Rheumatic Fever**	**Shortness of Breath**	
Sinus Infections	**Steroid Therapy**	**Stroke**	**Temporal Arteritis**	**Tuberculosis**	

Do you have any general health problems? Yes No

If so, please specify ____

Are you currently under the care of a physician? Yes No

Reason ____

Name and phone number of physician? ____

Are you currently taking any drugs or medications? Yes No

If so, please list:____

Have you had any surgeries? If so, please list ____

Do you have any known drug allergies? Yes No

If so, please list ____

DENTAL HISTORY

When was your last dental visit? __________________What did you have done? ______________________________

How long since your last *thorough* examination with *full mouth x-rays*? ______________________________

What prompted you to seek dental care at this time? ______________________________

Why did you leave your last dentist? ______________________________

What kind of treatment would you like? (**Circle One**)

Good - Basic care addressing your dental health issues

Best – Ideal treatment, the best available treatment in dentistry today addressing all your functional, cosmetic, and neuromuscular issues

Do you have any pain in your mouth at this time? Yes No

Do you have any TMJ pain? Yes No

Do you have headaches or neck pain? Yes No

Do you have muscle spasms or jaw pain? Yes No

Have you ever had any teeth removed? Yes No

How long have these teeth been missing? _______________

Do you want to replace any of your missing teeth? Yes No

Are you dissatisfied with your teeth in any way? Yes No

Are you dissatisfied with the way your teeth look? Yes No

Do you ever avoid any part of your mouth while chewing? Yes No

Are your teeth sensitive to heat, cold, sweets, or biting pressure? Yes No

Has fear of discomfort kept you from regular dental visits? Yes No

Does food constantly get stuck between certain teeth in your mouth? Yes No

If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? Yes No

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? Yes No

Do you want to learn to control dental disease and retain your teeth? Yes No

Are you deeply concerned about the finances required to return your mouth to excellent dental health? Yes No

How often do you brush your teeth? _____________________________How often do you use floss? ___________________________________

Is there anything not listed above that you would like to discuss with Dr. Khullar?

If so, please specify: ____

I agree that I have provided my personal, medical, and dental history to the best of my knowledge. I further agree that I am the person financially responsible for my account.

If you are not financially responsible for your account we will need the signature of the person who is responsible for your account

Printed Name ____

SIGNATURE____ Date ____________________

DENTAL INSURANCE INFORMATION

Who is responsible for this account? ____Relationship to patient __________________________

Insurance Company____ Group #____

Is the patient covered by additional insurance (yes or no) ______________Subscriber's Name _______________________________________

Birth date _________________ SS# _____________________ Relationship to patient ____

Insurance Company____ Group #____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with____

And assign directly to Dr. Denesh Khullar all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

SIGNATURE OF PATIENT/PARENT/GUARDIAN____

Name of Patient/Parent/Guardian______________

DATE_______________________________________RELATIONSHIP TO PATIENT____

HIPPA PATIENT CONSENT FORMS

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Dentalways has the right to change its Notice of Privacy Practices from time to time and that I may contact Dentalways at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name ____________________________________SIGNATURE____

RELATIONSHIP TO PATIENT____DATE___________________________

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our information and Insurance form before seeing the doctor.

● FULL PAYMENT IS DUE AT TIME OF SERVICES ● WE ACCEPT CASH, CHECKS AND CREDIT CARDS ●

REGARDING INSURANCE

We may accept assignment of insurance benefits after your second visit. However, we do require your estimated portion of the bill to be paid at time of services. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you make arrangements to take care of your balance by using one of our convenient payment methods. If your insurance company has not paid your account in full within 60 days, the balance will be automatically transferred to your credit card or one of our other payment options. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary by your Insurance Company. Regarding Insurance Plans where we are a provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

SCHEDULED APPOINTMENTS

I understand and agree to pay for the cost of appointments I have missed if I have not provided Dentalways with a notice of my intention to cancel my appointment within twenty-four (24) hours of my appointment time. I understand that my insurance coverage will not pay and will not be billed for missed appointments.

ADULT PATIENTS are responsible for full payment at time of service and **MINOR PATIENTS**
The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized for payment at time of service. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy and I understand and agree to the conditions of this policy.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY____**DATE**____________________

SIGNATURE OF CO-RESPONSIBLE PARTY____**DATE**____________________