Patient Name:

Welcome to our practice. In order for us to provide a higher level of care please complete these medical and dental history questionnaires. Please be assured that all the information will remain strictly confidential.

What is the reason for your visit today?____

____

Date of Last Dental Visit________ Last Dental Cleaning ________ Last Full Mouth X-Rays__________
What was done at your last dental visit?____

____

____

Name of previous dentist:____
Address:____
State:________ Zip:_________ Telephone:_____________________________________

How often do you have dental examinations? ___________________________________
How often do you brush your teeth?____________________How often do you floss?______________
What other dental aids do you use? (Waterpik, Tongue Scraper, etc.) ___________________________

Do you have any dental problems at this time? Yes☐ No ☐
If yes, please describe:____

Have you noticed any of the following:

Sensitivity to hot or cold: Yes☐ No☐
Sensitivity to sweets: Yes☐ No☐
Sensitivity to biting or chewing: Yes☐ No☐
Any mouth odor or bad taste: Yes☐ No☐
Cold sores, blister, or any other oral lesions: Yes☐ No☐

Periodontal or gum tissue concerns:

Do your gums bleed or hurt: Yes☐ No☐
Have your parents experienced gum disease or tooth loss: Yes☐ No☐
Have you noticed any loose teeth or changes in your bite: Yes☐ No☐
Does food tend to become caught in between your teeth: Yes☐ No☐
If yes, where?_______________________________________

Do you:

Clench or grind your teeth while awake or asleep: Yes☐ No☐
Bite your lips or cheeks regularly: Yes☐ No☐
Hold foreign objects with your teeth: Yes☐ No☐
(Pencils, pipe, pins, nails, fingernails, etc.)
Mouth breathe while awake or asleep: Yes☐ No☐
Have tired facial muscles, especially in the morning: Yes☐ No☐
Smoke or chew tobacco: Yes☐ No☐

Have you ever had:

Orthodontic treatment: Yes☐ No☐
Oral surgery: Yes☐ No☐
Periodontal treatment: Yes☐ No☐
Your teeth ground or adjusted: Yes☐ No☐
A bite plate or mouth guard: Yes☐ No☐
A serious injury to the mouth or head: Yes☐ No☐
Is so, please describe, including cause: ____________

____

Have you ever experienced:

Clicking or popping in the jaw: Yes☐ No☐
Pain (joint, ear, side of face): Yes☐ No☐
Difficulty in opening or closing your mouth: Yes☐ No☐
Headaches, neck aches, or shoulder aches: Yes☐ No☐
Sore muscles (neck, shoulders): Yes☐ No☐
An upsetting dental appointment: Yes☐ No☐
Is so, please describe, including cause: ____________

____

Are you:

Satisfied with the appearance of your smile: Yes☐ No☐
Committed to keeping all of your teeth: Yes☐ No☐
Nervous about having dental treatment: Yes☐ No☐
If so, what is your biggest concern?_______________

____

Is there anything else about having dental treatment you would like us to know? Yes☐ No☐
If yes, please describe____

____

____

Health History Innovative Dental Concepts

Patient Name:_______________________________ Birth Date:____

I. CHECK APPROPRIATE ANSWER:

#			Question
1	Yes☐	No☐	Is your general health good?
2	Yes☐	No☐	Has there been a change in your health within the last year?
3	Yes☐	No☐	Have you been hospitalized or had a serious illness in the last three years? If YES, why?__________
4	Yes☐	No☐	Are you being treated by a physician now? For what?__________ Date of last medical exam? __________

II. HAVE YOU EXPERIENCED:

#			Question	#			Question
5	Yes☐	No☐	Chest pain (angina)?	16	Yes☐	No☐	Dizziness?
6	Yes☐	No☐	Swollen ankles?	17	Yes☐	No☐	Ringing in ears?
7	Yes☐	No☐	Shortness of breath?	18	Yes☐	No☐	Headaches?
8	Yes☐	No☐	Recent weight loss, fever, night sweats?	19	Yes☐	No☐	Fainting spells?
9	Yes☐	No☐	Persistent cough, coughing up blood?	20	Yes☐	No☐	Blurred vision?
10	Yes☐	No☐	Bleeding problems, bruising easily?	21	Yes☐	No☐	Seizures?
11	Yes☐	No☐	Sinus problems?	22	Yes☐	No☐	Excessive thirst?
12	Yes☐	No☐	Difficulty swallowing?	23	Yes☐	No☐	Frequent urination?
13	Yes☐	No☐	Diarrhea, constipation, blood in stools?	24	Yes☐	No☐	Dry mouth?
14	Yes☐	No☐	Frequent vomiting, nausea?	25	Yes☐	No☐	Jaundice?
15	Yes☐	No☐	Difficulty urinating, blood in urine?	26	Yes☐	No☐	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

#			Question	#			Question
27	Yes☐	No☐	Heart disease?	38	Yes☐	No☐	HIV or AIDS?
28	Yes☐	No☐	Heart attack, heart defects?	39	Yes☐	No☐	Tumors, cancer?
29	Yes☐	No☐	Heart murmurs?	40	Yes☐	No☐	Arthritis, rheumatism?
30	Yes☐	No☐	Rheumatic fever?	41	Yes☐	No☐	Eye diseases?
31	Yes☐	No☐	Stroke, hardening of arteries?	42	Yes☐	No☐	Skin diseases?
32	Yes☐	No☐	High blood pressure?	43	Yes☐	No☐	Anemia?
33	Yes☐	No☐	Asthma, TB, emphysema, other lung diseases?	44	Yes☐	No☐	VD (syphilis or gonorrhea)?
34	Yes☐	No☐	Hepatitis, other liver disease?	45	Yes☐	No☐	Herpes?
35	Yes☐	No☐	Stomach problems, ulcers?	46	Yes☐	No☐	Kidney, bladder disease?
36	Yes☐	No☐	Allergies to: drugs, foods, medications, latex?	47	Yes☐	No☐	Thyroid, adrenal disease?
37	Yes☐	No☐	Family history of diabetes heart problems, tumors?	48	Yes☐	No☐	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

#			Question	#			Question
51	Yes☐	No☐	Psychiatric care?	56	Yes☐	No☐	Hospitalization?
52	Yes☐	No☐	Radiation treatments?	57	Yes☐	No☐	Blood transfusions?
53	Yes☐	No☐	Chemotherapy?	58	Yes☐	No☐	Surgeries?
54	Yes☐	No☐	Prosthetic heart valve?	59	Yes☐	No☐	Pacemaker?
55	Yes☐	No☐	Artificial joint?	60	Yes☐	No☐	Contact lenses?

V. ARE YOU TAKING or USING:

#			Question	#			Question
61	Yes☐	No☐	Recreational drugs?	63	Yes☐	No☐	Alcohol?
62	Yes☐	No☐	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies? Please list:__________ __________	64	Yes☐	No☐	Tobacco in any form?

VI. WOMEN ONLY:

#			Question	#			Question
65	Yes☐	No☐	Are you or could you be pregnant or nursing?	66	Yes☐	No☐	Taking birth control pills?

VII. ALL PATIENTS:

67 Yes☐ No☐ Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication(s).

Patient's signature:______________________________ Date: Doctor's Initials: __________

RECALL REVIEW

Patient's signature:______________________________ Date: Doctor's Initials: __________

Patient's signature:______________________________ Date: Doctor's Initials: __________

Patient's signature:______________________________ Date: Doctor's Initials: __________

Patient Information

Email ____________________________

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _________________

Social Security #: ________________________________ Birth Date: ______________________________

Phone (Home): ________________ (Work): ________________ Ext:______ Cell phone __________________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________________________ Occupation: _____________________________

Address: ____

Street City State Zip Code

Insurance Information of Self, Spouse or Responsible Party

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #:______________________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other___________________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #:______________________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other___________________

Insurance Plan Name and Address: ____

____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ____________ Relationship to Patient: ___________________

Signature of patient, parent or guardian

____ Date: ____________ Relationship to Patient: ___________________

Signature of guarantor of payment/responsible party

How were you referred to our office ?____

Office Financial Policy & Important Information Regarding Your Dental Insurance

Welcome to our office and thank you for putting your trust in us for your oral health. Our office strives to make your visits with our office as pleasant as possible. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

We accept cash, personal checks, debit card, Master Card, Visa, Discover Card, and American Express. In addition, we offer an excellent third party financial payment plan for balances over $500. Our office staff would be happy to provide you with more detailed information on this plan if you are interested. Outstanding balances older than 90 days are subject to finance charges at the rate of *1.5%* monthly. Returned checks are subject to a $25 administrative fee in addition to any outstanding amount. In the unfortunate event that your account needs to be forwarded to a collection agency you will be responsible for your outstanding balance, accrued interest, and any collection agency charges that may be imposed.

If you have dental insurance, you must bring proof of insurance to your appointments and we will be more than happy to submit your insurance claims for you. However, you must realize:

1. *Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.*

2. *We cannot render services on the assumption the charges will be paid for by an insurance company. All charges on all accounts for which you serve as the guarantor are your responsibility from the date the services are rendered.*

3. *Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.*

4. *Please remember to update our office staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.*

You may direct the insurance company to pay their share of the cost directly to our office (Assignment of Benefits). Often, we do not receive these payments until two to three months after being submitted for payment therefore you will be required to pay your estimated share at the time treatment is rendered. Upon receipt of the insurance payment we will reconcile your account and bill or refund any difference. In the event that your insurance company does not pay within 90 days of rendering treatment, please understand that the guarantor of your account is not responsible for this outstanding balance.

We must emphasize that as dental care providers, our relationship is with you, the patient and not your insurance company. While filing the insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above information, please do not hesitate to ask us. We are here to serve you.

I have read the policies described in this form. I agree to abide by the terms outlined. I fully understand and accept my financial responsibilities,

*X*____ _________________________________

Signature of Responsible Party *Date*

Innovative Dental Concepts, Dental Practice of Parag R. Kachalia, DDS Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CALIFORNIA DENTAL MATERIALS FACT SHEET

****You May Refuse to Sign This Acknowledgement****

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

I, ___________________________________, have received a copy of the *California Dental Materials Fact Sheet.*

____
{Signature} {Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and *California Dental Materials Fact Sheet*, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

____

____