

Bella Doshi, D.D.S.

1. PATIENT INFORMATION

Date _____

Name: _____ SS# _____
Last First Middle

Address _____

City _____ State _____ Zip _____

Sex: M F Age: _____ Birth Date _____
 Married Widowed Single Separated Divorced Partnered for _____ years Minor

Occupation _____

Employer _____

Employer Address _____

Employer Phone #: _____

Name of School _____

Spouses Name: _____

Birthdate: _____ SS# _____

Occupation: _____

Spouses Employer & Address: _____

Whom may we thank for referring you? _____

2. CONTACTS

Home:() _____ Work:() _____ Cell:() _____

E-mail: _____

Best time and place to reach you? _____

IN CASE OF AN EMERGENCY, CONTACT (specify someone who does live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

3. DENTAL INSURANCE

Who is responsible for this account?: _____

Relationship to patient? _____

Insurance Company? _____

Group Number: _____

Subscriber Name: _____

Birthdate: _____ SS# _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Bella Doshi 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 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.

Responsible Party Signature

Date

4. HEALTH HISTORY

Name of physician: _____

Phone: _____

Date of last complete physical?: _____

Have you had any serious illness or operations? _____

Yes No _____

Are you taking any medications now? _____

Yes No _____

Have you been treated for?

Have you taken PhenPhen Yes No

Heart Disease Yes No

Rheumatic Fever Yes No

Congenital Heart Lesions Yes No

Heart Murmur Yes No

Artificial Heart Valves Yes No

Artificial Joints Yes No

Tuberculosis/Lung Disease Yes No

Diabetes Type I Type II Yes No

Epilepsy Yes No

Anemia Yes No

Abnormal Blood Pressure Yes No

Kidney Problems Yes No

Stroke Yes No

Glaucoma Yes No

Venereal Disease Yes No

Hepatitis or Liver Problems Yes No

Or have been in contact with _____

anyone with Hepatitis Yes No

Ulcers Yes No

Jaundice Yes No

Asthma/Hay Fever Yes No

Sinus Trouble Yes No

Cough Yes No

Malignancies/Tumors Yes No

Chemotherapy Yes No

Cancer Yes No

Arthritis Yes No

Thyroid Disease Yes No

Psychiatric Treatment Yes No

Do you smoke? Yes No

How many packs per day? _____

Have you ever been treated (other than diagnostic) with x-rays/radiation Yes No

Are you allergic to: Penicillin _____ Codeine _____ Sulfa _____ Local Anesthetics _____

Please list any other allergies _____

Are you subject to prolonged bleeding? Yes No

Are you subject to fainting spells? Yes No

Do you have excessive urination and /or thirst? Yes No

Women: are you pregnant? Yes No

Are you taking birth control? Yes No

Have you been exposed or treated for HIV or AIDS? Yes No

Have you been exposed or diagnosed to have aids related complex (ARC)? Yes No

Do you have a history of?:

Prolonged, unexplained fever (90 days) Yes No

Unexpected weight loss? Yes No

Lymphadenopathy? Yes No

Prolonged sore throat? Yes No

Blood Transfusion? Yes No

Injectable drug use? Yes No

Do you have any disease, condition or problem not listed above that you think I should know about?

UPDATES (for completion of dentist)

Date _____

Has there been any changes in your health since your last dental visit? Yes No

Doctor's Signature

Patient's Signature

Date _____

Has there been any changes in your health since your last dental visit? Yes No

Doctor's Signature

Patient's Signature

5. DENTAL HISTORY

Reason for today's visit: _____

When was your last dental visit?: _____

Have you ever had any serious health problems associated with previous dental treatment? Yes No

If so, explain: _____

Is there anything we can do to make your experience more pleasant? _____

What texture brush do you use? Soft Medium Hard Nylon Natural

How often do you brush your teeth? _____

How often do you floss? _____

Do your gums bleed when brushing? Yes No

Do your gums bleed when flossing? Yes No

Do you avoid brushing any part of your mouth because of pain?

Yes No _____

Are your teeth sensitive to Hot Sweet Chewing

Cold Sour

Do you feel pain to any of your teeth when brushing or flossing? Yes No _____

Do you chew on only one part of your mouth? Yes No _____

Do you hear popping, clicking, or snapping noises when you chew? Yes No _____

Do your gums feel tender or swollen? Yes No _____

Do you clench or grind your jaw while sleeping or during the day? Yes No _____

Does your jaw ever feel tired, or do you have pain in or near the ear? Yes No _____

Do you wear dentures or partials? Yes No _____

Are you aware of any swelling or lumps in your mouth? Yes No _____

Do you often get cavities? Yes No _____

Do you loose fillings or break fillings? Yes No _____

Do you gag easily? Yes No _____

Are you familiar with the term "preventative dentistry"? Yes No _____

Do you have any loose teeth? Yes No _____

Have you had any periodontal treatment? Yes No _____

How do you feel about your teeth? _____

Are you happy with your smile? _____

COMMENTS (for completion of dentist)

ACKNOWLEDGEMENT & AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicines, performance of operations and conduct of Lab, x-rays, or other studies that may be used by the attending doctor, her assistant or hygienist.

Signature of Patient/Guardian

Date

Bella Doshi, D.D.S.

It is a pleasure to serve your dental needs and discuss treatment with you. We are pleased you have chosen to place the care of your dental health with us. Be sure that the most thorough conscientious service will be dedicated to this trust. My staff and I pride ourselves in providing the best dentistry available and making dentistry a pleasant experience.

During your first visit a thorough examination will be completed. This will include necessary x-rays or other aids necessary to make an accurate diagnosis. We will then determine your dental treatment, discuss our recommendations with you and make financial arrangements. We would appreciate your payment for this initial examination at the time of your visit.

Except for emergency treatment, you can expect us to be on time for you, and we will appreciate the same courtesy.

APPOINTMENTS

A minimum charge of **\$50.00** will be made for failed or cancelled appointments without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still have to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE

To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that the patient is personally responsible for payment of fees. We do not render our services on the basis that insurance companies will pay all our fees. We will prepare necessary forms or reports to help obtain your benefits from insurance companies. However, full or partial payment of the bill is necessary before submitting forms for payment. If only partial payment is made, benefits must be assigned to the attending dentist.

If you have dental coverage please provide us with the information. If you have any questions regarding your insurance, please feel free to ask. We will be happy to help you.

FINANCIAL POLICY

All services are to be paid in full at the time they are rendered unless other financial arrangements have been made. This office limits all accounts to 30 days without a late payment charge of 1.5% (18% APR). This charge will be placed on all past due accounts.

We accept Visa, MasterCard, American Express, Discover and CareCredit.

There will be a **\$25.00** charge for any returned checks.

I understand and agree to the above policies. I hereby acknowledge that I have received a copy of HIPPA & Your Privacy Rights from Bella Doshi, D.D.S. and a copy of the Dental Materials Fact Sheet.

Signature of Patient/Guardian

Date