DENTAL DEPOT Á Patient Information and Consent to Treatment

This form must be filled out completely and signed before any treatment can be rendered.

Patient name: ______________________________ **Email :** ____________________
Marital status: ______________________________ **Date of birth** _____/______/_____
Street address: ______________________________ **Home phone:** ________________
City: ________________________, **Zip:**__________ **Cell Phone:** ________________
Soc. Security # ______-________-_______ **Sex:** **Female ❑** **Male ❑**
Spouses Name: ______________________________
Responsible party name: ______________________________ **Date of Birth:** ____/_____/_____
Responsible party address:______________________________ **Soc. Security #** ____-_____-_____
Dental Insurance: ______________________________ **Policy/group#** ________________
Policy holder's name: ______________________________ **Occupation::** ________________
Policy holder's employer: ______________________________ **Drivers license** ________________
Work phone #: ________________
Emergency Contact: ______________________________ **and phone #** ________________

Referred by: ❑Friend/name________________ ❑Train/Bldng ❑Yellow Pages ❑Radio

MEDICAL HISTORY OF PATIENT – CONFIDENTIAL

What dental concerns or problems do you have today? ______________________________

Please rate your current dental health: **Excellent ❑ Good ❑ Fair ❑ Poor ❑**

Please rate your current general health: **Excellent ❑ Good ❑ Fair ❑ Poor ❑**

Current medical doctor: ______________________________ Date of last exam**:** ____________

Address of med. doctor: ______________________________ Ph. # of med. doctor: ____________

Please check the box if you have now or have ever had any of the following: ❑

						Endocrine disorders	❑
Diabetes	❑	**Heart murmur**	❑	**Low blood pressure**	❑	**Epilepsy**	❑
Hepatitis	❑	**Heart disease**	❑	**Respiratory Problems**	❑	**Pacemaker**	❑
HIV or AIDS	❑	**Joint replacement**	❑	**Bleeding problems**	❑	**Jaundice**	❑
Rheumatic fever	❑	**High blood pressure**	❑	**Artificial Heart Valves**	❑	**Stroke**	❑
Cold Sores	☐	**Anemia**	☐	**Asthma**	☐	**Hemophilia**	☐

Do you have any other medical problems not listed above? YES ❑ NO ❑ If **yes**, briefly describe other medical problems or any significant changes in your current health:

____

If you have Blood pressure problems, are they under control? YES ❑ NO ❑
If problems, briefly describe:

____

Do you use **alcohol** or beverages containing alcohol? YES ❑ NO ❑ If Yes, How Often?

____

Do you **smoke** or use **smokeless tobacco**? YES ❑ NO ❑ If Yes, what ________________and how Often?
____

Have you been exposed to AIDS? YES ❑ NO ❑

Have you been exposed to Hepatitis? YES ❑ NO ❑

Are you currently taking any medications or prescriptions? YES ❑ NO ❑

If **yes**, please list all medications you are currently taking:______________________________

You may use the back of this form to answer the medical questions if necessary.

Are you allergic to: **penicillin❑ codeine❑ latex❑ local anesthetics❑ other** ______________

If female, are you pregnant? YES ❑ NO ❑ If yes, how long? ___________

If female, are you currently nursing? YES ❑ NO ❑ If yes, how long? ___________

Are you subject to prolonged bleeding? YES ❑ NO ❑ If yes, why? ______________

CONSENT FOR TREATMENT

By my signature below, I consent to the examination and treatment by Dr. Himesh I. Kana and the DENTAL DEPOT DOCTORS AND STAFF. I understand that dentistry is not an exact science and therefore the results of any treatments performed may vary from patient to patient. I understand that occasionally, additional treatment may be required. Also, by my signature below I hereby certify the correctness and completeness of the medical history information above, (and on the back of this form if more space was needed). **I also agree that payment will be made at time treatment is rendered, and that any balance unpaid by insurance is my responsibility.**

Patient signature ______________________________ Date ______________________

Custodial parent or legal guardian must sign for consent to treatment if patient is a minor or legally incapacitated.

Dental Depot of Highland Village

Dr. Himesh Kana and Dr. Neil Patel

Our mission is to provide the highest quality of dental care. We strive to educate all of our patients on good oral hygiene. We will take time to complete a comprehensive exam and explain all your dental options. Please take a moment and answer the following questions.

When was the last time you had a cleaning and complete exam?________

What, if anything, would you like to change about your smile?

If you snore, how does your partner say it affects his or her ability to sleep?____

In terms of your dental health, do you have any concerns?_______________

Describe any headaches/jawjoint/TMJ problems you have._______________

Have you considered straightening your teeth with orthodontics (braces) or Invisalign (clear braces)?______ Would you like to go over your options?_________

We place dental implants in our office. Let us know if we can answer any questions about missing teeth?____

How can we make your dental experience better?___________________________

<u>Whitening For Life</u>

As a reward program we have Free Whitening for Life for our patients. Would you like for us to explain our rewards program to you? YES or NO

<u>Gift of Referral Program</u>

On the back of our business card we have a referral program that credits both your account and the referred patient $25.00 that can be used for dental treatment or other dental purchases. (Not for cash value) The patient you refer **<u>must</u>** bring the filled out referral card with them to the appointment.

For your comfort, we have blankets, pillows and tinted eye protection.

NOTICE OF PRIVACY PRACTICES ACKNOLEDGEMENT

Himesh I Kana DDS
Neil Patel DMD
The Dental Depot of Highland Village
2460 FM 407
Highland Village, Texas 75077
Phone (972)966-1234 Fax (972) 966-1233

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third party players.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I understand that I may ask for the full length Notice to Privacy Practices that is a more complete description of the uses and disclosures of my health information. I also understand that the Dental Depot of Highland Village has the right to change its Notice to Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice to 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.

Patient Name ____

Relationship to Patient ____

Signature ____

Date ____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice to Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date__________Initials_____________Reason_______________________________________

Appointment Policy

The time we reserve for your appointment is very important. As a courtesy, we'll will call to remind you of your appointment. Please give 24 hours notice if you are unable to keep a scheduled appointment to avoid a $50.00 missed appointment/short notice cancellation fee. Missed or broken appointments on Saturday will be charged a $65.00 fee.

Insurance And Payment Policy

We file insurance as a courtesy to our Patients. Payment for any amount not covered by your insurance plan is due at the time of service. Your insurance policy is a contract between you and your insurance company. It is your responsibility to pay any deductible, co-insurance, or any balance which is not paid by your insurance company. For your convenience, we accept, Visa, Mastercard, Discover, American Express and Care Credit.

I have read and I understand both of the above policies.

____Date_________________________________