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 (specifysomeone 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# _____

ASSIGMENT 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 pa id 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❒	Hepatitis or Liver Problems	Yes❒	No❒
Heart Disease	Yes❒	No❒	Or have been in contact with		
Rheumatic Fever	Yes❒	No❒	anyone with Hepatitis	Yes❒	No❒
Congenital Heart Lesions	Yes❒	No❒	Ulcers	Yes❒	No❒
Heart Murmur	Yes❒	No❒	Jaundice	Yes❒	No❒
Artificial Heart Valves	Yes❒	No❒	Asthma/Hay Fever	Yes❒	No❒
Artificial Joints	Yes❒	No❒	Sinus Trouble	Yes❒	No❒
Tuberculosis/Lung Disease	Yes❒	No❒	Cough	Yes❒	No❒
Diabetes Type I Type II	Yes❒	No❒	Malignancies/Tumors	Yes❒	No❒
Epilepsy	Yes❒	No❒	Chemotherapy	Yes❒	No❒
Anemia	Yes❒	No❒	Cancer	Yes❒	No❒
Abnormal Blood Pressure	Yes❒	No❒	Arthritis	Yes❒	No❒
Kidney Problems	Yes❒	No❒	Thyroid Disease	Yes❒	No❒
Stroke	Yes❒	No❒	Psychiatric Treatment	Yes❒	No❒
Glaucoma	Yes❒	No❒	Do you smoke?	Yes❒	No❒
Venereal Disease	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 you 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 or 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