WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #:____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age:_____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext:_____

Cell Phone #: (_____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

three ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____) _____

Payment method: ❑ Cash ❑ Check

_____ /____

❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

four IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____) _____

PLEASE CONTINUE ON BACK

five 5

DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth

❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw

❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath

❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ (____) _____
Name Phone#

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

six 6

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

What medications are you taking? ❑ **Nerve pills** ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**
❑ **Other(s), please list:** _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin

❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

Have you ever taken the drug Phen-fen and or Redux? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments

Monika Bhatia DDS PLLC
267 Old Country Rd.
Hicksville, NY 11801

Consent for General Dental Care

I, the undersigned hereby authorize doctor to order x-rays, study photographs, and any other diagnostic aid deemed appropriate by doctor to make a diagnosis of the patient's dental needs. I, also authorize doctor to perform all recommended Treatment mutually agreed upon by me and to use the appropriate medication and Therapy indicated for such treatment connection with
(Name of Patient)_____

I understand that using anesthetic agents embodies a certain risk. Furthermore I, authorize and consent the doctor choose and employ such assistances as Deemed fit to provide recommended treatment.

I understand that as the treatment proceeds there may be need to change the treatment plan. If that occurs I expect to be informed before any change is instituted.

I further understand that individual reactions to treatment cannot be predicted, and that if I, experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible.

I understand that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, and reporting to the office any change in my health status as soon as possible.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

_____ Date_____
Patient's Signature

_____
If a Minor, Signature of Parent or Guardian

Authorization for Signature on File

I,_____ hereby authorize the office of Monika Bhatia DDS PLLC to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with
_____. I hereby authorize payment of dental benefit otherwise payable to me, directly to the office listed above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or portion of such charges. To the extent permitted under applicable law, I authorize release of any information relation to the claim.

This Authorization will be valid from this date. A photocopy of this document may act as an original.

Signature_____Date_____

Monika Bhatia DDS PLLC
267 Old Country Rd.
Hicksville NY, 11801

Financial Policy

Thank you for choosing us for your dental needs. In an effort to provide
Quality care to our patients and to avoid any misunderstandings, we would like to inform you of our office policy regarding payment for services rendered.

Payment is expected at the time treatment is performed.

As a courtesy to our patients with dental benefits, we will submit your claim to your primary insurance company. Any portion not expected to be covered by these benefits is the ***responsibility of the patient and due at the time the service is rendered.*** This amount will include deductibles and co-payments. If benefit amounts are less than Expected, you will be billed for the difference and payment is due within 10 days.

Dental benefits are contracts between the policyholder, their employers and the insurance company, we are not party to this contract

We will make every effort to assist you with any benefit questions, however we suggest that you be aware of what benefits you have available. Ultimately, you are responsible for the balance.
Marital status is not a consideration under any circumstance. Decreed custody or lack thereof, does not alter financial responsibility. The parent accompanying the child/minor on the day of service will be considered the responsible party.

For your convenience, we accept: **Cash, Check, Visa, MasterCard, and *Care Credit**
*A dental credit card payment program. Ask our staff for details.

Bookkeeping Rewards

A. 5% Reward - pre-payment of entire fee upon scheduling of appointment.
B. 5% Senior Reward (60 years old qualifies) not to be used in conjunction with assignment of benefit or prepayment reward

Even if **you have dental insurance,** it is acceptable to take advantage of the 5% pre-payment bookkeeping rewards. Simply make full payment minus the bookkeeping reward. We will file your insurance forms and instruct your insurance company to send payment directly to you.

Overdue Accounts

1. Finance charges of **1 ½ %** per month will be added to overdue accounts.

2. Accounts over 60 days old will be sent to a collection agency and will have additional fees added to their account. In the event your account becomes delinquent, you will be responsible for collection fees, attorney fees and court costs.

3. There is a $25.00 charge for returned checks. If a check is returned and not paid within 7 days of return date, legal action may be taken for collection. Any costs associated with collection of returned checks will be assumed by you.

APPOINTEMENT POLICY

Our office makes every attempt to remain on schedule throughout the day. We value you time and will do our best to keep you from having to wait. We reserve appointments for you. We do not double book our patients. In case of emergencies and appointments which run longer than anticipated we ask for your patience and that you keep in mind that you may be the next one needing our extra attention.

As a courtesy, our office will attempt to contact you for confirmation 1-2 days before your appointment. However, we do ask that patients/parents assume responsibility for their appointment time.

Broken appointment or short term cancellations (within 24 hours) without proper notification can be costly and unfair to other patients who need appointments. Repeated broken appointments and short term cancellation may be subject to dismissal from the practice. Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule if time allows or re –appointment to another day.

We require 48 hours notice for cancellation or rescheduling of an appointment. If 48 hours is not given, a $50.00 broken appointment fee may be charged.

Notice of Privacy Practices

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

By signing below, you understand and accept the terms of our **Financial Policy**, **Broken Appointment Policy**, and acknowledge receipt our **Notice of Privacy Practices.**

Signature of Responsible Party _____ **Date** _____
* *Patient, Parent, or Legal Guardian*

Monika Bhatia DDS PLLC
267 Old Country Rd.
Hicksville, NY 11801

Notice of Privacy Practices

This Notice Describes How Health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect (05/01/05), and will remain in effect until we replace it.

We reserve the rights to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of health information
We use disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operation: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals.

Your Authorization: In additional to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revolve it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To your family and friends: We must disclose your health information to you, as described in the patient's rights section of this notice. We may disclose your health information to a family member, friends or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Person involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the people's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions; medical supplies x-rays, or other similar forms of health information.

Marketing Health related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or a possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters.

Patient rights

Access: You have the right to look at or get copies of your health information, with limited expectations. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will change you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $5.00 for each page, $50.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or and explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the light to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April14, 2003. If you request this accounting more than once in a 12-month period, we may change you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (expect in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (You request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

Question and Complaints

If you want more information about our privacy practices or have question or concerns, please contact us.

If you are concerned that we have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complaint to us using the contact information listed at the end of this notice. You also may submit a written complaint with the U.S. Department of health and human Services. We will provide you with the address to file your complaint with the U.S Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

Contact Office: Monika Bhatia Telephone (516) 935-5391 Fax (516) 935-5392
267 Old Country Rd. Hicksville, NY 11801