Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can.
If you have questions we'll be glad to help you.

Patient Information

Name _____ SOC. Sec. #_____
Last Name *First Name*

Prefers to be called _____ Male _____ Female _____

Address _____

City _____ State_____ Zip _____ E-mail _____

Home Telephone (___) - _____ Cell/pager # (___) - _____

Patient Employed by:_____ Occupation _____

Business Address _____ Business Telephone (___) - _____

Birth date (M/D/Y) _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Notify In Case of Emergency _____ Tel:(___) - _____

Whom May We Thank For Referring You?_____

Primary Insurance / Person Responsible for Account ☐

Person Responsible for Account _____
Last Name *First Name*

Relation to Patient _____ Birth date _____ SOC. Sec.# _____

Address *(if different from Patient)*_____ Home Phone _____

City _____ State_____ Zip _____ E-mail _____

Home Telephone (___) - _____ Business Telephone (___) - _____

Insurance company name_____ Phone (___) - _____ Group # _____

Name of other dependents under this plan _____

Is patient covered by additional Insurance? ___Yes ___No

Consent

1. I herby authorize Dr. Dipa Mehta D.D.S. and/or designated staff to take study models, photographs, and other diagnostic aids.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to such assistance as required to provide proper care.
3. I agree to use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I have read and understood the Dental Material Fact Sheet dated Oct 17, 2001.

Patient Signature X _____ Date_____

Parent/Responsible Part's Signature X _____

Welcome

Additional Insurance ☐

Subscriber _____
Last Name *First Name*
Relation to Patient _____ Birth date _____ SOC. Sec.# _____
Address *(if different from Patient)* _____ Home Phone( ) -
City _____ State _____ Zip _____ E-mail _____
Home Telephone ( ) - Business Telephone ( ) -
Person Responsible Employed by: _____ Occupation _____
Insurance company name _____ Phone _____
Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Insurance Assignment of Benefits Agreement & Financial Policy

We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

- As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, and Visa. Outside financing is available through Dental Fee Plan upon request and approval.
- ***All Medical/Dental records and X-Rays are properties of this office any costs to transfer to another practitioner will incur a duplication fee of $25. I understand there will be $50 fee for any missed or broken appointments without 48-hour prior notice. I also understand that the cancellation of scheduled appointment for Dental Cleaning may result in having to miss a regular three, four, or six-month appointment.***
- In the event of returned check an additional amount of $15 for processing will be charged. We cannot accept a personal or business check to replace NSF items. Payment for the amount of the check plus $15 must be paid in cash, cashiers check, or money order. The NSF is charged for any reason such as insufficient funds or closed account. Balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims:

- **We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.**
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.
- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- *I have read and understand the above terms and conditions. I authorize my insurance company to pay me dental benefits directly to the doctor.*

_____
Print Name Signature of Patient/Responsible Party Date

Dipa Mehta D.D.S. **Tel: (408) 732-0220**

Patient Name

Patient Account No.

MEDICAL HISTORY

Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin? ..... Yes No
   If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)? ..... Yes No
   If yes, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phentermine)
   Yes No Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluramine)
   If yes to any of the above, did you have a medical exam for heart issues? ..... Yes No
5. Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? ..... Yes No
   If yes, please list _____
   Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you use more than two pillows to sleep? ..... Yes No
9. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
10. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
    If yes, please list: _____
11. **Women.** Are you: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

Patient Name

Patient Account No.

DENTAL HISTORY

Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely 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? _____

_____

Previous Dentist's Name _____

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? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
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 change 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? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

_____

(Please complete other side)