PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ (FIRST / MI / LAST) DATE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

REGISTRATION

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM: _____		
4. PHYSICIANS'S NAME _____ PHONE NO. _____		
5. ARE YOU UNDER THE CARE OF A PHYSICIAN	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____	☐	☐
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	☐	☐
8. HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
9. HAVE YOU HAD A RECENT WEIGHT LOSS/GAIN	☐	☐
10. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS	☐	☐
11. DO YOU USE TOBACCO	☐	☐
12. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	☐	☐
13. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	☐	☐
14. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED BELOW THAT YOU THINK WE SHOULD KNOW ABOUT	☐	☐

WOMEN ONLY:	YES	NO
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT.	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATE, SEDATIVES, OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER (PLEASE LIST) _____		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
ACID REFLUX	☐	☐
AIDS OR HIV INFECTION	☐	☐
ALLERGIES	☐	☐
ANEMIA	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
ASTHMA OR HAY FEVER	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
CHEST PAIN	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
CORTISONE TREATMENT	☐	☐
DIABETES	☐	☐
EPILEPSY OR SEIZURES	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
GLAUCOMA	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART SURGERY	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
HIGH / LOW BLOOD PRESSURE	☐	☐
HIVES OR SKIN RASH	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
MENTAL HEALTH CARE	☐	☐
MEMORY LOSS	☐	☐
MIGRAINES	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
MORNING DRY MOUTH	☐	☐
MUSCLE SPASMS OR CRAMPS	☐	☐
NERVOUSNESS	☐	☐
NIGHTTIME SWEATING	☐	☐
PACEMAKER	☐	☐
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
SHORTNESS OF BREATH	☐	☐
SINUS TROUBLE	☐	☐
STOMACH ULCER	☐	☐
STROKE	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
THYROID PROBLEMS	☐	☐
TONSILLITIS	☐	☐
TUBERCULOSIS	☐	☐
TUMORS	☐	☐

PATIENT'S DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS / FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS / FOODS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT?	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE?	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOU HAD ANY ORTHODONTIC WORK.	☐	☐
DO YOU SNORE OR HAVE YOU BEEN TOLD YOU SNORE?	☐	☐
HAVE YOU EVER BEEN TOLD YOU STOP BREATHING WHILE YOU SLEEP?	☐	☐
DO YOU FEEL EXCESSIVELY SLEEPY DURING THE DAY?	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

I AUTHORIZE THE DENTISTS TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERDED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PAYMENT IS DUE IN FULL AT TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

DOCTOR'S COMMENTS _____

_____ SIGNATURE _____ DATE _____

Nivedita Nijhawan, D.D.S., Inc

1382 E Alluvial Ave, Suite # 104. Fresno, CA-93720. Ph no. (559) 224-1303, Fax (559) 225-3236

Financial Agreement

Welcome to our practice. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal dental care easy and manageable to our patients by offering several payment options.

Unless you have worked out a financial plan with our office, all expenses incurred are to be paid in full 60 days from the original date of service. The policy of this office is to charge 1% monthly (12% annual percentage rate) to all accounts 90 days past due with minimum monthly charge of $5.00. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. **All patient co-pays, deductible and co-insurance are due at the time of service.**

An account with an unpaid balance past 90 days will be sent to collection agency, unless other financial arrangements have been made. You will be responsible for any and all costs incurred in the collection of your account.

Personal checks, cash and most major credit cards are accepted. We are pleased to offer **CARECREDIT** as an extended payment option. We will gladly give you details on how to apply.

We do offer 10% cash discounts for patients with no insurance who pay the same day of service bringing their balance to zero. A 10% discount for senior citizens who are 65 years of age and older, who have no insurance.

As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you supply us with an insurance card and all the information necessary to verify your coverage and file your claim. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you not your insurance policy.

Although we may provide an estimate of your insurance benefits we are not responsible for their accuracy. Knowledge of benefits amount, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.

Our practice is committed to providing the best treatment for our patients and we strive to charge what is usual and customary rates for our area. You are responsible for payment regardless of insurance company's arbitrary determination of usual and customary rates.

Appointments not kept or changed with less than 24 hours notice are considered broken. You must notify us at least 24 hours in advance to avoid a missed appointment fee of $50 "NO SHOW FEE" with no exceptions. We take them seriously so please be considerate and inform us in advance if you need to change your appointment as we can render dental care to another patient who needs one.

Again, thank you for choosing us to provide you with quality dental care. We appreciate your trust in us and value the opportunity to serve you.

I understand the terms of this agreement and agree in full to it. I understand the consequences if my account is not paid within the specified amount of time as described in this agreement.

Acknowledgment of receipt of financial agreement.

_____

Patient Name, Parent/ Guardian if minor

_____ _____

Patient Signature **Date**

Revised 6/1/2018

Nivedita Nijhawan, D.D.S., Inc.

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPPA Notice of Privacy Practices.**

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual notes above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement.

___ A communication barrier prevented us from obtaining acknowledgement.

___ The individual was unwilling to sign.

___ Other: _____

_____ _____
Staff Member Signature Date