

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
FIRST MI LAST STATE/PROV. ZIP/P.C.  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
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 \_\_\_\_\_

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_

ADDRESS \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

EMPLOYER \_\_\_\_\_

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

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? _____

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? _____

Team 051-5767; 2010 Patterson Office Supplies 800-637-1140

X

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		YES	NO												
1. ARE YOU IN GOOD HEALTH .....	<input type="checkbox"/>	<input type="checkbox"/>	9. HAVE YOU HAD A RECENT WEIGHT LOSS/GAIN .....	<input type="checkbox"/>	<input type="checkbox"/>												
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR ....	<input type="checkbox"/>	<input type="checkbox"/>	10. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS ....	<input type="checkbox"/>	<input type="checkbox"/>												
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			11. DO YOU USE TOBACCO .....	<input type="checkbox"/>	<input type="checkbox"/>												
4. PHYSICIANS'S NAME _____ PHONE NO. _____			12. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES .....	<input type="checkbox"/>	<input type="checkbox"/>												
5. ARE YOU UNDER THE CARE OF A PHYSICIAN ...	<input type="checkbox"/>	<input type="checkbox"/>	13. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS) ....	<input type="checkbox"/>	<input type="checkbox"/>												
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS ...	<input type="checkbox"/>	<input type="checkbox"/>	14. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED BELOW THAT YOU THINK WE SHOULD KNOW ABOUT .....	<input type="checkbox"/>	<input type="checkbox"/>												
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>WOMEN ONLY:</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">YES</th> <th style="width: 10%; text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT ..</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>ARE YOU NURSING .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>ARE YOU TAKING BIRTH CONTROL PILLS .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>				YES	NO	ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT ..	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU NURSING .....	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU TAKING BIRTH CONTROL PILLS .....	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO															
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT ..	<input type="checkbox"/>	<input type="checkbox"/>															
ARE YOU NURSING .....	<input type="checkbox"/>	<input type="checkbox"/>															
ARE YOU TAKING BIRTH CONTROL PILLS .....	<input type="checkbox"/>	<input type="checkbox"/>															
IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____																	
8. HAVE YOU HAD ANY ABNORMAL BLEEDING ...	<input type="checkbox"/>	<input type="checkbox"/>															

	YES	NO		YES	NO
<b>ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:</b>					
LOCAL ANESTHETICS LIKE NOVOCAINE .....	<input type="checkbox"/>	<input type="checkbox"/>	HEART DEFECT OR HEART MURMUR .....	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS .....	<input type="checkbox"/>	<input type="checkbox"/>	HEART SURGERY .....	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS .....	<input type="checkbox"/>	<input type="checkbox"/>	HEART TROUBLE, HEART ATTACK, OR ANGINA .....	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATE, SEDATIVES, OR SLEEPING PILLS .....	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS, JAUNDICE OR LIVER DISEASE .....	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN .....	<input type="checkbox"/>	<input type="checkbox"/>	HIGH / LOW BLOOD PRESSURE .....	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.) ..	<input type="checkbox"/>	<input type="checkbox"/>	HIVES OR SKIN RASH .....	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER .....	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT .....	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			LUNG OR BREATHING PROBLEMS .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:</b>			MENTAL HEALTH CARE .....	<input type="checkbox"/>	<input type="checkbox"/>
ACID REFLUX .....	<input type="checkbox"/>	<input type="checkbox"/>	MEMORY LOSS .....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS OR HIV INFECTION .....	<input type="checkbox"/>	<input type="checkbox"/>	MIGRAINES .....	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIES .....	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE .....	<input type="checkbox"/>	<input type="checkbox"/>
ANEMIA .....	<input type="checkbox"/>	<input type="checkbox"/>	MORNING DRY MOUTH .....	<input type="checkbox"/>	<input type="checkbox"/>
ARTHRITIS OR RHEUMATISM .....	<input type="checkbox"/>	<input type="checkbox"/>	MUSCLE SPASMS OR CRAMPS .....	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER .....	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS .....	<input type="checkbox"/>	<input type="checkbox"/>
BACK PROBLEMS .....	<input type="checkbox"/>	<input type="checkbox"/>	NIGHTTIME SWEATING .....	<input type="checkbox"/>	<input type="checkbox"/>
CHEMICAL DEPENDENCY .....	<input type="checkbox"/>	<input type="checkbox"/>	PACEMAKER .....	<input type="checkbox"/>	<input type="checkbox"/>
CHEMOTHERAPY (CANCER, LEUKEMIA) .....	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER .....	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN .....	<input type="checkbox"/>	<input type="checkbox"/>	SCARLET FEVER .....	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM .....	<input type="checkbox"/>	<input type="checkbox"/>	SHORTNESS OF BREATH .....	<input type="checkbox"/>	<input type="checkbox"/>
CORTISONE TREATMENT .....	<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE .....	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES .....	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER .....	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY OR SEIZURES .....	<input type="checkbox"/>	<input type="checkbox"/>	STROKE .....	<input type="checkbox"/>	<input type="checkbox"/>
FAINTING OR DIZZY SPELLS .....	<input type="checkbox"/>	<input type="checkbox"/>	SWELLING OF FEET, ANKLES, HANDS .....	<input type="checkbox"/>	<input type="checkbox"/>
GLAUCOMA .....	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS .....	<input type="checkbox"/>	<input type="checkbox"/>
			TONSILLITIS .....	<input type="checkbox"/>	<input type="checkbox"/>
			TUBERCULOSIS .....	<input type="checkbox"/>	<input type="checkbox"/>
			TUMORS .....	<input type="checkbox"/>	<input type="checkbox"/>

## 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		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING			DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY ..	<input type="checkbox"/>	<input type="checkbox"/>
OR FLOSSING .....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF		
ARE YOUR TEETH SENSITIVE TO HOT OR COLD			YOUR TEETH .....	<input type="checkbox"/>	<input type="checkbox"/>
LIQUIDS / FOODS .....	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT		
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR			BETWEEN YOUR TEETH .....	<input type="checkbox"/>	<input type="checkbox"/>
LIQUIDS / FOODS .....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH .....	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY HEAD, NECK OR JAW INJURIES ..	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS .....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING			IF YES, DATE OF PLACEMENT _____		
PROBLEMS IN YOUR JAW?			HAVE YOU HAD ANY ORTHODONTIC WORK. ....	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING .....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU SNORE OR HAVE YOU BEEN TOLD YOU		
PAIN (JOINT, EAR, SIDE OF FACE) .....	<input type="checkbox"/>	<input type="checkbox"/>	SNORE? .....	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY IN OPENING OR CLOSING .....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER BEEN TOLD YOU STOP BREATHING		
DIFFICULTY IN CHEWING .....	<input type="checkbox"/>	<input type="checkbox"/>	WHILE YOU SLEEP? .....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE FREQUENT HEADACHES .....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU FEEL EXCESSIVELY SLEEPY DURING THE DAY?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU CLENCH OR GRIND YOUR TEETH .....	<input type="checkbox"/>	<input type="checkbox"/>			

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 RENDERED 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

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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.**

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**Patient Name, Parent/ Guardian if minor**

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**Patient Signature**

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**Date**

**Revised 6/1/2018**

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**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**