Preston Bend Dental (972-618-1111)

Anita Naik Madhav D.D.S.

Date: _____ Referral Source: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____ Preferred: _____

SS#:_____ Birth Date: _____ Sex: Male / Female

Home Address: _____

(street) (city, state) (zip)

Email Address: _____

Patient's Home #:_____ Patient's Work #:_____

Patient's Cell #: _____ Any Other #:_____

Employer:_____ Occupation:_____

Emergency Contact Name: _____ Relationship:_____

Emergency Contact Phone #: _____

DENTAL HISTORY

Reason for today's visit:_____

Former Dentist: _____ Date of last dental care: _____

How often do you brush?_____ Floss? _____

Do you use a manual or motorized tooth brush? _____ What brand?_____

Are you happy with your smile? _____

Please check if you have experienced **ANY** *of the following (please mark* **ALL** *responses)*

Bad Breath	☐ YES	☐ NO	Heat Sensitivity	☐ YES	☐ NO
Biting Sensitivity	☐ YES	☐ NO	Loose Teeth	☐ YES	☐ NO
Bleeding Gums	☐ YES	☐ NO	Jaw Joint Pain	☐ YES	☐ NO
Broken Fillings	☐ YES	☐ NO	Orthodontic Treatment	☐ YES	☐ NO
Cold Sensitivity	☐ YES	☐ NO	Periodontal Treatment	☐ YES	☐ NO
Food Collection	☐ YES	☐ NO	Sores/Growths in Mouth	☐ YES	☐ NO
Grinding Teeth	☐ YES	☐ NO	Sweet Sensitivity	☐ YES	☐ NO

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give a copy of the office notice of privacy practices and make a good faith effort to obtain an acknowledgement of receipt of same. By signing below, I confirm that I have read/received a copy of the notice of privacy practices. You may refuse to sign this acknowledgement but, in refusing we will not be allowed to process your insurance claims; therefore payment in full is due on the day of services rendered.

Print Patient Name: _____

Patient Signature: _____ **Date:** _____

MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Physician's Name: _____ **Phone #:** _____

Date of Last Physician Visit: _____ **Pharmacy and number:** _____

Please check if you have experienced **ANY** *of the following (please mark* **ALL** *responses)*

Abnormal Bleeding	☐ YES	☐ NO
AIDS (HIV+)	☐ YES	☐ NO
Alcohol/Drug Abuse	☐ YES	☐ NO
Allergies	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Artificial Joints	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Artificial Heart Valves	☐ YES	☐ NO
Back Problems	☐ YES	☐ NO
Blood Disease	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Chemotherapy	☐ YES	☐ NO
Cortisone/Steroid Treatment	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO
Heart Problems	☐ YES	☐ NO
Hepatitis/Liver Disease	☐ YES	☐ NO
Herpes/Fever Blisters	☐ YES	☐ NO
Chest Pains	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Take Aspirin/Blood Thinner	☐ YES	☐ NO
Undergone Cancer Treatment	☐ YES	☐ NO
Have Taken Bisphosphanates	☐ YES	☐ NO
Have Taken Fosamax	☐ YES	☐ NO

Epilepsy	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Kidney/Bladder Disease	☐ YES	☐ NO
Pace Maker	☐ YES	☐ NO
Psychiatric Care	☐ YES	☐ NO
Radiation Treatment	☐ YES	☐ NO
Rheumatic Fever	☐ YES	☐ NO
Shortness of breath	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Thyroid Problems	☐ YES	☐ NO
Tobacco Habit	☐ YES	☐ NO
Tonsillitis	☐ YES	☐ NO
Tuberculosis/Emphysema	☐ YES	☐ NO
Mitral Valve Prolapse	☐ YES	☐ NO
Ulcer	☐ YES	☐ NO

Women Only:

Currently On Birth Control Pills	☐ YES	☐ NO
Currently Nursing	☐ YES	☐ NO
Currently Pregnant	☐ YES	☐ NO

***Women of Childbearing age**:*
Please note that there may be a reduced effectiveness of oral steroid contraceptives during antibiotic therapy. Therefore, we advise you to use additional/alternate forms of contraception during antibiotic use.

Are you taking any medications? ☐ YES ☐ NO

Please list any medications you are taking:

_____

_____

Are you **ALLERGIC** to any medication, anesthetic, or materials such as zippers, costume jewelry, latex gloves, etc.?

☐ YES ☐ NO If yes, please explain:_____

_____

Do you have any disease or condition, hospitalization, surgery, or anything about your health that we have not covered that we may need to know?

☐ YES ☐ NO If yes, please explain:_____

_____

*Dr. Madhav Initials:*_____ *Date:* _____

ADMINISTRATIVE POLICY

- In order to provide true personalized dental care, **we are NOT a network provider with any insurance policy**. That means we do not sign contracts with insurance companies to treat you according to what benefits them financially. Only you, the patient, in consultation with the doctor, will decide what dental services are rendered.
- Insurance Policies are a contract between you and the insurance company. The final responsibility for payment rests with you, the consumer. As a courtesy, we file all insurance claims on behalf of our patients.
- Payment for services is due at the time services are rendered. For services that qualify, we can arrange for low monthly payments through a third party financing company. We accept cash, checks, and all major credit cards. The bank charges us a service fee for all returned checks which we will pass on to you if your check is dishonored.
- If after 60 days from the date of service a balance has not been paid, collection efforts may commence.
- Out of courtesy to other patients and the office staff, please give at least 48 hours notice for an appointment cancellation. We reserve the right to charge $100 for cancellations with less than 48 hours notice.
- The parent or guardian who brings the child in for their visit is responsible for payment irrespective of what a divorce decree may state.
- Before commencing any treatment, you will be provided a written treatment plan with all of the recommended treatment and associated fees.
- It is the responsibility of you, the patient, to inform this office of any changes in your medical status or contact information.

INSURANCE OPTIONS

*We offer **TWO** payment Options. Please tell us which payment method you prefer by signing below:*

Option One

To avoid monthly statements or bills, our patients have the option to pay for their entire visit **IN FULL** on the date of service. As a courtesy, we file all insurance claims for our patients. If you would like Option One, please sign below:

Option One: Patient Signature:_____ **Date:**_____

Option Two

Our patients have the option to pay only the **ESTIMATED** patient portion on the day of your appointment. Should your insurance pay any less than we have estimated, we will send you a statement in the mail. Our patients who choose this option are expected to pay any remaining balance. If you would like Option Two, please sign below:

Option Two: Patient Signature:_____ **Date:**_____

ACKNOWLEDGEMENT

By signing below, I acknowledge:

I have read, understand and accept the above Administrative Policy.

I authorize Dr. Madhav and staff to release any information concerning my case to my insurance company if applicable.

I authorize Dr. Madhav and staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Print Patient Name: _____

Patient Signature: _____ **Date:** _____

Office use:

___Emergency situation prevented obtaining signature

___Unable to communicate with patient

Reviewed by:

Authorization for Use or Disclosure of Protected Health Information

By signing this form, I authorize Preston Bend Dental to use and disclose my Protected Health Information described below to:

Share my Protected Health Information with:
(Please initial applicable authorization.)

____No One

____My spouse: _____

____My mother/father/child (ren)/guardian *(Cross out and initial those not applicable.)*

____The following person(s) _____

____Disclose my protected health information for the following reasons

(Please initial those applicable.)

____ To leave an appointment reminder on my ____ Cell phone ____ Work phone _____ Home phone

Other: _____

I understand that I have the right to revoke this authorization at any time by notifying the following:

Preston Bend Dental
7600 San Jacinto Pl, Ste 100
Plano, TX 75024

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the law or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I have the right to decline signing the authorization to disclose my protected health information. This will not in any way effect my treatment.

I have the right to review the Protected Health Information to be used or disclosed or to refuse to sign this authorization. Preston Bend Dental reserves the right to receive compensation dependent on the circumstances of disclosure.

I am personally responsible to inform Preston Bend Dental, should there be any changes to any of the above.

_____ Signature of Patient or Personal Rep. If Minor

_____ Print Name of Patient

_____ Date

_____ Description of Personal Rep.'s Authority If Minor

PRESTON BEND DENTAL

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PLANO TX 75024
(972) 665-0966
INFO@PRESTONBENDDENTAL.COM

Insurance Verification Explained…

To help patients understand what their out-of-pocket costs may be, we call your insurance company and specifically ask them **what they will pay on your procedures**. Unfortunately, insurance carriers will often not release specific information and sometimes are completely wrong about coverage and payout information.

We "**ESTIMATE**" what they will pay based on deciphering their percentage coverage as told to us by a telephone representative from your insurance carrier. Our estimates are our best educated guess at what they will pay. Please do not solely rely on our estimates to determine whether you want to undertake treatment or not. Because if for some reason, insurance fails to pay, the patient is responsible for the entire cost of services.

Please initial each statement below:

1. I have **not** relied on any insurance estimates to determine whether to undertake treatment:_____

2. I understand insurance estimates are just estimates and do **not** hold Preston Bend Dental responsible for the accuracy of any estimates: _____

Patient Name: _____ Date: _____