PLEASE PRINT
CONFIDENTIAL PATIENT RECORD

PATIENT NAME: ________________________________ DOB (MM/DD/YYYY): _____________

ADDRESS: ____________________________________ STATE: _______ ZIP: ____________

SOCIAL SECURITY NUMBER: __________________________ MARITAL STATUS: _________

HOME PHONE: ___________________ WORK: _______________ CELL: _________________

REFERRED BY: ____________________ EMAIL ADDRESS: ____________________________

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY NAME: ___________________________ PHONE: _______________

EMPLOYER: ____________________ GROUP #: ________________ ID #: ________________

NAME OF POLICYHOLDER: _________________ SS#: _________________ DOB: __________

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO.

HIGH BLOOD PRESSURE	YES NO	KIDNEY DISEASE	YES NO
HEART ATTACK	YES NO	AIDS/HIV INFECTION	YES NO
PACEMAKER	YES NO	THYROID DISEASE	YES NO
HEART MURMUR	YES NO	RADIATION THERAPY	YES NO
HEART DISEASE	YES NO	TUBERCULOSIS	YES NO
STROKE	YES NO	ANEMIA	YES NO
ANGINA	YES NO	EMPHYSEMA	YES NO
ASTHMA	YES NO	CANCER	YES NO
JOINT REPLACEMENT	YES NO	SEXUALLY TRANSMITTED DISEASE	YES NO
LEUKEMIA	YES NO	PROSTHETIC HEART VALVE	YES NO
DIABETES	YES NO	LOW BLOOD PRESSURE	YES NO
ARTHRITIS	YES NO	BLEEDING PROBLEMS	YES NO
RHEUMATIC FEVER	YES NO	HEPATITIS (PLEASE SPECIFY TYPE)	YES NO
EPILEPSY/CONVULSIONS	YES NO	OTHER (PLEASE LIST): __________________	

Medical History Review
(for office use only)

Date	Initial

HAVE YOU BEEN HOSPITALIZED WITHIN THE LAST 5 YEARS? PLEASE DESCRIBE:

____

PLEASE LIST ALL CURRENT MEDICATIONS: _____________________________________

PLEASE LIST ANY ALLERGIES: ____

PHYSICIAN'S NAME: ____

ARE YOU/IS THERE ANY CHANCE THAT YOU'RE PREGNANT? ____ DUE DATE: _______

DO YOU SMOKE? ___ HOW MUCH PER DAY? ___ DO YOU USE CHEWING TOBACCO? __

Dental History:

Are you having discomfort at this time? YES NO

if so, please specify_______________

Have you been under the regular care of a Dentist? YES NO

How long since your last dental visit?_______________

What was done at that visit? _______________

Are your gums tender or swollen? YES NO

Are you aware of any lumps or swelling in your mouth? YES NO

Are you anxious to keep your natural teeth? YES NO

Would you like to have Whiter teeth? YES NO

Describe what you would like to have done with your teeth:

____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING?
(CIRCLE ALL THAT APPLY TO YOU)

LOOSE TEETH
SENSITIVE TEETH
EARACHES
HEADACHES
SORE GUMS
BLEEDING GUMS
MISSING TEETH
GAGGING
UNSATISFACTORY DENTURES
POPPING OR CLICKING IN JAW
SPACED OR CROOKED TEETH
BAD BREATH
OTHER:_______________

CONSENT:

I understand the use of anesthetic agents embodies a certain risk. I also certify that I have read and understand the above information. To the best of my knowledge, all health and dental history questions contained herein have been answered accurately . I understand that providing incorrect information may be detrimental to my health. The undersigned hereby authorized Dr. Desai to take x-rays,study models, photographs and/or any other diagnostic aids deemed necessary to make a thorough diagnosis of the patients dental needs.

As a courtesy we will file your dental insurance claims for you. However, co-payments and or deductibles are collected at the time services are renderedunless other formal arrangements are made prior appointments. If services are denied by insurance for any reason, you ARE RESPONSIBLE FOR THE BALANCE.

By signing below, I acknowledge that I have been made aware that it is customary for this office to render composite /resin for posterior teeth. Most insurance companies consider this to be cosmetic and only allow the amount that they would consider to pay for amalgam/silver fillings. The difference in cost is the patients responsibility.

Our office is dedicated to giving you, our patient , the best care to the best of our ability, not to the ability of the insurance company to pay.

I also agree that if I cancel or miss an appointment without giving at least 24 hours notice, I will be responsible for a “broken appointment” charge of $40.00 per half hour of scheduled time.

SIGNATURE: I certify that I have read and understand the above consent information.

_______________ _______________

SIGNATURE OF PATIENT , OR GUARDIAN DATE

Privacy Notice and Consent

Dr. Desai and Staff believe our patients have the right to privacy and that their personal financial and health information should be kept confidential. New laws, however, require that we notify you about our privacy policy in writing.

How do we use your personal health information?

We will use your health information to provide, coordinate. And/or manage your dental treatment and any related services. This may include providing necessary information to pharmacy personnel, laboratory technicians, or third party health care providers. For example, we might need to disclose information as necessary to a home health agency that provides care to you, or to a Physician or Dental specialist to whom you may have been referred. To ensure that they have the necessary information to properly diagnose and treat you. ALSO, your personal information may be released to your insurance company, if necessary, to facilitate payment of your claims.

On occasion, your personal information may be used in/for supporting our practice's business operations. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, licensing and conducting or arranging for other business activities. We may use a sign in sheet at the reception desk, where you will be asked to sign your name. We may also call you by name in the reception area when ready to bring you in for your visit. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may also use or disclose your personal information in the following situations without your authorization as required by law

- **Public Health Issues/Communicable diseases.**
- **Abuse or Neglect**
- **Food and Drug Administration requirements**
- **Legal proceedings/Law Enforcement ,Criminal Activity or National Security**
- **Coroners Request**
- **Research**
- **Workers Compensation issues**

Other permitted and required uses and disclosures will be made only with your consent, authorization, and opportunity to object unless otherwise required by law.

You may revoke this authorization at any time, in writing, except to the extent that your dentist or practice has taken an action in reliance on the use or disclosure indicated in the authorization.

What are your rights?

- You have a right to inspect and copy your personal information.
- You have a right to request a restriction of your personal information. This means you may ask us not to use or disclose any of your personal information for the purposes of treatment, payment or business operations. You may also request that any part of your information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described herein. Your request must state specific restriction requested, in writing and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit the use and disclosure of such information , it will not be restricted. You then have the right to use another healthcare professional or facility.
- You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
- You have the right to have your dentist amend your personal health information.
- You have the right to receive an accounting of certain disclosures we have made of your personal health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You have the right to express complaints to the practice and to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with the Privacy Officer, verbally or written, using the contact information above. You will not be retaliated against for filing a complaint. **This notice published and becomes effective on or before 4/14/2003**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our main office number.

By signing below I certify that I have read and understand the above information. By signing I am giving Dr. Desai and his staff permission to release my personal information as described above.

________________________________ ________________

Signature of Patient or Guardian **Date**

Desai Dental Studio

1510 SE 47th Terrace

Cape Coral, FL 33904

There will be a no show charge in the amount of **$92** for all appointments that were not cancelled **24 hours in advance**. We set aside this time for you.

Patient Name: ______________________________

Date: ______________________________

<u>Desai Dental Studio</u>

<u>Financial Policy</u>

Welcome to Desai Dental Studio. We would like to thank you for selecting Dr. Sudhandhu B. Desai, DDS as your provider. To avoid any misunderstanding regarding our Financial Policy, it is necessary for you to **<u>read, initial, and sign</u>** as indicated before treatment can be rendered.

Desai Dental Studio participates with most PPO insurance carriers. <u>The patient is responsible for any co-pay, co-insurance and any deductible</u>. This payment is due at the time of service_________ (initial). Our office will file insurance claims for services rendered.

<u>Self Pay Patients</u>: Payment is due at the time of service________ (initial).

<u>Finance Plans</u>: There will be a 5% administrative fee added to your treatment for Care Credit, Dental Fee Plan or Citi Health Card __________ (initial).

<u>Finance Charge, NSF Fees and Collection Fees</u>: Balances unpaid after 90 days are the patient's responsibility and will be charged a fee of 1.5% or 18% APR. Insufficient funds or returned check will be assessed a $30.00 fee. Patients are responsible for any collection fees including court costs, attorney fees and collection agency charges. __________ (initial).

<u>Care Credit Patients</u>: There will be a 5% administrative fee added on to any treatment _______.(initial)

<u>Note for Insurance Patients</u>: Your payment given at the time of service is only an estimate. We do not know exactly what your insurance will cover if any. Any insurance problems are between you and your insurance carrier. You are responsible for the difference if your insurance company does not pay.________ (initial).

<u>Insurance Authorization</u>: I authorize payment of dental benefits directly to Desai Dental Studio for dental services rendered.

_____________________________   ______________________

Patient (or guardian) Signature   Date