Welcome to Dr. Patel & Dr. Knight's Office

ABOUT YOU

Patient's Name:________________________ Prefer to be called:______________ MALE ☐ FEMALE ☐

Address:________________________________ City:______________ State:______ Zip:__________

Birth Date:______________ Social Security #:________________ Email:______________________

Home #:________________ Cell #:____________________ Work #:____________________

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer:______________________________ Spouse's Name:______________________________

Occupation:____________________________ Spouse's Employer:__________________________

Phone #:_______________________________ Phone #:____________________________________

Reason for today's visit? ____

Emergency Contact:______________________ Relationship:______________ Phone #:______________

IF PATIENT IS A CHILD

Father's Name:__________________________ Mother's Name:______________________________

Address (If different from above): Address (If different from above):

______________________________________ ______________________________________

Date of Birth:______________ SS#:______________ Date of Birth:______________ SS#:______________

Employer:______________________________ Employer:___________________________________

Position:_______________________________ Position:____________________________________

Phone #:_______________________________ Phone #:____________________________________

DENTAL INSURANCE

Primary Ins. Co.:________________________ Secondary Ins. Co.:__________________________

Insured's Name:__________________________ Insured's Name:______________________________

Social Security #: ______________DOB:__________ Social Security #: ______________DOB:__________

Policy/Group #: _________________________ Policy/Group #:______________________________

Person responsible for account:________________________________ Phone #:__________________

Billing Address (If different from above):____

Who may we thank for referring you? ☐ Location ☐ Internet ☐ Website ☐ Patient Referral/Other:________________

Please read and check each box below:

☐ I authorize my insurance company to pay Rima B. Patel, DMD, PC benefits that otherwise are payable to me directly.

☐ I authorize Rima B. Patel, D.M.D., PC to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care, to third party payers and/or health practitioners. A photocopy of this authorization shall be as valid as the original.

☐ 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 on behalf of my dependents. It is my responsibility to pay the deductible amount, co-insurance, or any other balance not paid by insurance. If this account is assigned to an agency for collection and/or suit, then I shall be responsible for agency fees and costs of collection.

Patient (or Guardian) Signature:_____________________________________ Date:________________

Patient's Name: ____ Phone # ___________________________

MEDICAL HISTORY

Your CURRENT physical health is ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ No ❑ Yes

Please explain (if answer is yes) ____

Are you taking any prescription / over the counter drugs? ❑ No ❑ Yes

Please list each one ____

____

FOR WOMEN

Are you Pregnant? ❑ No ❑ Yes (Week # ______) Are you nursing? ❑ No ❑ Yes

Are you taking birth control pills? ❑ No ❑ Yes

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

❑ Heart Attack	❑ HPV (Human Papilloma Virus)	❑ Blood Transfusion
❑ Cancer / Chemotherapy	❑ Fever Blisters	❑ Venereal Disease
❑ Stroke	❑ Severe / Frequent Headaches	❑ Hemophilia / Abnormal Bleeding
❑ Rheumatic Fever	❑ Drug / Alcohol Abuse	❑ Kidney Problems/dialysis or transplant
❑ HIV + AIDS	❑ Smoke / Use tobacco	❑ Ulcers / Colitis
❑ Heart Surgery / Pacemaker	❑ Psychiatric Problems	❑ Radiation Treatment
❑ High / Low Blood Pressure	❑ Epilepsy / Seizures	❑ Arthritis
❑ Artificial Bones / Joints	❑ Fainting Spells	❑ Asthma
❑ Artificial Valves	❑ Diabetes	❑ Hepatitis
❑ Immune System Disorder	❑ Tuberculosis	❑ Blood clots

Any other medical conditions not listed above that we need to know about? ____________________________

Are you allergic to any of the following? ❑ Penicillin ❑ Aspirin ❑ Minocycline ❑ Tetracycline ❑ Codeine ❑ Latex ❑ Dental Anesthetics ❑ Other _______________

DENTAL HISTORY (Please check all that apply)

❑ Yes ❑ No Have you ever had a bad dental experience or are you nervous when you are visiting the dentist?

❑ Yes ❑ No Are any of your teeth sensitive to hot or cold foods or drinks?

❑ Yes ❑ No Do you clench or grind your teeth?

❑ Yes ❑ No Do you have any clicking in your jaw, pain while chewing, difficulty when opening or closing?

❑ Yes ❑ No Have you ever had or are interested in Botox for cosmetic or therapeutic purpose to treat jaw pain or headaches?

❑ Yes ❑ No Have you ever had or are interested in dermal fillers to enhance your lips or to reduce folds and wrinkles?

❑ Yes ❑ No Are you interested in closing spaces or straightening your teeth?

❑ Yes ❑ No Are you happy with the color of your teeth?

Are there any other dental concerns that you would like us to address?______________________________

____

I understand that the information that I have given today is correct to the best of my knowledge. I authorize Rima B. Patel, DMD, PC to perform any treatment deemed necessary. I understand that this information will be held in the strictest confidence and it is my responsibility to inform Rima B. Patel, DMD, PC of any changes in my medical history.

Patient (or Guardian) Signature ______________________________________ **Date:** ________________

Medical History reviewed:

Sign / Date **Sign / Date** **Sign / Date**

Privacy Practices and Consent Form

Acknowledgement of review of notice of privacy practices and consent for use and disclosure of health information.

To the patient - Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. In addition, I give full consent to Rima B. Patel, DMD, PC for any and all dental treatment as planned by the doctor. The doctor will discuss all treatment plans with the patient.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about you protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact: Rima B. Patel, DMD, PC
Address: 23 Old Atlanta Highway, Suite 200, Newnan, GA 30263
Telephone: 770-251-6868 Fax: 770-683-6872
Email: info@newnandentistry.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, ______________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I have reviewed a copy of this office's Notice of Privacy Practices.

Signature: ____ **Date:** ____________________

If this Consent is signed on behalf of the patient, complete the following:

Representative's Name: ______________________________________ Relationship: ___________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

OUR POLICY REGARDING DENTAL INSURANCE

Please be advised that we are an "out of network" provider. As a courtesy to our patients, we will be happy to complete and forward insurance forms relative to dental treatment, and we will do so without charge.

However, in order to avoid misunderstandings, please read carefully and understand the following policies in regard to dental insurance benefits.

- To serve and assist you in utilizing your dental insurance, this office accepts assignment of your insurance benefits. Please provide us with your dental insurance card, if you have one, or your insurance group name and number.

- In an effort to reduce our paperwork, we ask that you take care of any deductible and/or co-payment due on the date that treatment is rendered.

- Some policies request a "pre-authorization" or "pre-determination" before treatment is begun. We will submit a treatment plan for review by your insurance company if this is a requirement.

Please remember that dental insurance is designed to assist people to obtain dental care and rarely covers more than 30 to 50 percent of the total cost of service. There may be a deductible, a co-insurance factor, and a yearly maximum to be considered.

Most policies cover what they consider a "usual and customary fee". However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this office.

All of these factors may contribute in reducing the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan. We will be happy to discuss financial arrangements with you to help cover treatment costs not covered by dental insurance.

Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. At your request, this office will provide all pertinent information to your insurance company and we will do our best to help you derive the maximum benefits available. However, we are not responsible for determining what those benefits are to be. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer. To learn more about dental insurance, visit our website at www.NewnanDentistry.com.

Thank you,

Dr. Rima B. Patel