WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs in a timely manner please complete these forms and return them to us or bring them with you. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Today's Date ______________________________

Name ______________________ Prefer to be called ______________

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthdate ______________________ Soc. Sec. # ______________________

Address ______________________________

City, State, Zip ______________________________

Home Phone ______________ Work Phone ______________ Ext. ________

Cell Phone ______________________ Email ______________________

Employer ______________________ Occupation ______________________

Where do you prefer to be contacted? ☐ Home ☐ Work ☐ Cell ☐ Email

When is the best time to reach you? Time ________ Day of week ______________

In the event of an emergency, who should we contact?

Name______________ Relationship______________ Work #__________ Home #__________

Whom may we thank for referring you: ______________________________

2 Responsible Party

Who is responsible for the account? (If different from above)

Name ______________________________

Relationship to patient ______________________________

Birthdate ______________________ Driver's License # ______________________

Soc. Sec. # ______________________________

Address ______________________________

City, State, Zip ______________________________

Employer ______________________________

Occupation ______________________________

Work Phone ______________________ Ext. # ______________________

Home Phone ______________________________

3 Insurance Information

Primary Insurance

Name of Insured ______________________________

Relationship to patient ______________________________

Insured's birthdate ______________________________

Soc. Sec. # ______________________________

Employer ______________________________

Date Employed ______________________________

Occupation ______________________________

Insurance Company ______________________________

Group # ______________________________

Employee/Cert. # ______________________________

Ins. Co. Address ______________________________

Deductible ______________________________

Amount already used ______________________________

Max. annual benefit ______________________________

Additional Insurance

Name of Insured ______________________________

Relationship to patient ______________________________

Insured's birthdate ______________________________

Soc. Sec. # ______________________________

Employer ______________________________

Date Employed ______________________________

Occupation ______________________________

Insurance Company ______________________________

Group # ______________________________

Employee/Cert. # ______________________________

Ins. Co. Address ______________________________

Deductible ______________________________

Amount already used ______________________________

Max. annual benefit ______________________________

4 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other 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 ____

Signature of patient or parent if minor Date

5 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

______ Cash

______ Personal Check

______ Credit Card ___ Visa ___ MC

______ I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

FORM 175796 R/11/01 ITEM 8101 COLWELL SYSTEMS 1.800.637.1140

Health History

NAME________________________ BIRTHDATE__________ TODAY'S DATE__________

Medical History

Are you in good health? ❒ Yes ❒ No

Have there been any changes in your general health within the past year? ❒ Yes ❒ No

Name of your Physician ____________________________

Date of last medical exam ____________________________

Reason for exam ____________________________

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

	Yes	No
Local Anesthetics like Novocaine	❒	❒
Penicillin or other Antibiotics	❒	❒
Sulfa Drugs	❒	❒
Any metals (nickel, mercury, etc.)	❒	❒
Latex / Rubber	❒	❒

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	Yes	No
Heart Trouble, Angina	❒	❒
Heart Attack	❒	❒
Chest Pain	❒	❒
Heart Defect or Heart Murmur	❒	❒
Mitral Valve Prolapse	❒	❒
Pacemaker	❒	❒
Heart Surgery	❒	❒
High/Low Blood Pressure	❒	❒
Shortness of Breath	❒	❒
Hepatitis, Jaundice or Liver Disease	❒	❒
Stroke	❒	❒
Sinus Trouble	❒	❒
Lung or Breathing Problems	❒	❒
Asthma or Hay Fever	❒	❒
Fainting or Dizzy Spells	❒	❒
Diabetes	❒	❒
Cancer	❒	❒
Chemotherapy	❒	❒
Radiation Treatment	❒	❒
Thyroid Problems	❒	❒
Arthritis or Rheumatism	❒	❒
AIDS or HIV infection	❒	❒
Joint replacement or implant	❒	❒
Stomach Ulcer	❒	❒
Kidney Trouble	❒	❒
Tuberculosis	❒	❒
Persistent Cough	❒	❒
Cough that produces blood	❒	❒
Sexually Transmitted Disease	❒	❒
Epilepsy or Seizures	❒	❒
Anemia	❒	❒
Nervousness	❒	❒
Tumors	❒	❒
Mental Health Care	❒	❒
Chemical Dependency	❒	❒
Cortisone Treatment	❒	❒
Cold Sores/Fever Blisters	❒	❒
Eating Disorders	❒	❒

Do you smoke?	❒	❒
Do you use smokeless tobacco?	❒	❒

Please list all, including nonprescription, medicines you are taking:

Medication:	Taken for:

Do you have any other problem or condition that might affect your dental care? ____________

Signature ____________________________ Date ____________

Dental History

1. Reason for today's visit: ____________________
2. When was your last dental care? ____________________
3. When was your last dental x-ray taken? ____________________

	YES	NO
4. Do your gums bleed while brushing?	❐	❐
5. Do your gums bleed when flossing?	❐	❐
6. Do you feel pain to any of your teeth when brushing or flossing them?	❐	❐
7. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	❐	❐
8. Have you noticed any loosening of your teeth?	❐	❐
9. Does food tend to become caught between your teeth?	❐	❐
10. Do you have any sores or lumps in or near your mouth?	❐	❐
11. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	❐	❐
b. Pain (joint, ear, side of face)?	❐	❐
c. Difficulty in opening or closing?	❐	❐
d. Difficulty in chewing?	❐	❐
12. Have you had any head, neck, or jaw injuries?	❐	❐
13. Do you have frequent headaches?	❐	❐
14. Do you clench or grind your teeth while awake or asleep?	❐	❐
15. Do you bite your lips or cheeks frequently?	❐	❐
16. Have you ever had:		
a. Orthodontic treatment (braces)?	❐	❐
b. Oral surgery?	❐	❐
c. Gum treatment?	❐	❐
d. Your teeth ground or the bite adjusted?		
e. Worn a bite plane or other appliance?	❐	❐
f. An allergic reaction to jewelry?	❐	❐

17. Would you like to change anything about the appearance of your teeth?

____

____

____

18. Have you ever had an upsetting experience in the dental office, please explain?

____

____

____

19. Is there anything about having dental treatment that bothers you, please explain?

____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

FORM 179016 R/12/01 ITEM 8101

Murtuza Shah-Khan, DDS, PLLC

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: ______________________________

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

______________________________ ______________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  ____

- ☐ Other: ______________________________________

  ____

Prepared by ______________________________

Signature ______________________________

Date ______________________________

Authorization for Release of Information - Compound Release

Name of Patient ______________________________ Date of Birth ________________

Murtuza Shah-Khan, DDS, PLLC is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voicemail	☐ Appointment Reminders ☐ Other: ______________________
☐ Other person (s) (provide name and phone number) (Example: Spouse, Parent, Relative, Friend, Stepparent) ☐ ______________________ ☐ ______________________	☐ Financial ☐ Treatment Plans
☐ Email communication - Provide email address* ______________________	☐ Financial ☐ Treatment ☐ Appointment Reminders ☐ Breach Notification
☐ Text communication - Provide number * ______________________ *For text communication to occur, accept the disclosure below:	☐ Appointment Reminder ☐ Other: ______________________

☐ For **text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive text communication as selected.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

______________________________ Date ________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Jan 2018