Hilliard Advanced Dentistry
Healthy Smiles for a Lifetime

NEERU SHARMA DDS, MS
COSMETIC, IMPLANT & GENERAL DENTISTRY

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WELCOME

Thank you for selecting our dental healthcare team! To help us meet all your dental health care needs, please complete the following confidential information. If you have any questions nor need assistance, please ask us and we will be happy to help. We are committed to providing you a lifetime of healthy teeth through successful appointments. Please understand that comprehending our payment system allows for smoother transition through various treatment phases. The following is a summation of our financial policy. We require that you acknowledge this and our Patient Registration Form/Questionnaire by signature prior to any treatment.

PATIENT INFORMATION

Patient Name:________________________ ________________________ Prefers to be called by:__________
Last First M.I.

[ ] Male [ ] Female Age _____ [ ] Married [ ] Single [ ] Child [ ] Other __________________

Birth Date: ________Social Security # ________ Drivers License #: ______________________________

Address:______________________________________ ______________________________________
Street Apartment #

____
City State Zip Code

Email: ____

Phone (Home): (______) __________ ________________________Work: (______) _____________ Ext ____

Best time to call:_______ ____

Fax: (______) ________________ Pager: (______) ________________ Cell: (______) ___________________

Preferred appointment times: [ ] Morning [ ] Afternoon [ ] Any Time Preferred Days: [ ] m [ ] t [ ] w [ ] th [ ] f

EMPLOYMENT INFORMATION

The following information is for: [ ] The Patient [ ] The Responsible Party (Relationship to patient) _____________

Employer Name:________________________________Occupation:______________Phone No.: (_____) _______

Address:______________________________________ ______________________________________
Street City State Zip Code

PERSONAL AND REFERRAL INFORMATION

Whom may we thank for referring you to our practice? [ ] Another patient, friend [ ] Another patient, relative

[ ] Another Dental Office [ ] Work [ ] Yellow Pages [ ] Other ____

Name of the person referring you to our practice: ____

Person to contact in case of emergency:

Name: ____ Phone: (______) __________

Address:______________________________________ ______________________________________
Street City State Zip Code

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: ___________________________________ Relationship to Patient:_______________
Last First M.I.

Birth Date: ________Social Security # ________ __Drivers License #: ______________________________

Address:______________________________________ ______________________________________
Street Apartment #

____
City State Zip Code

Email: ____

Phone (Home): (______) __________ ________________________Work: (______) _____________ Ext ____

Fax: (______) ________________ Pager: (______) ________________ Cell: (______) ___________________

INSURANCE INFORMATION

Primary Insurance:

Patient's relationship to insured: [ ] Self [ ] Spouse [ ] Child [ ] Other ____________________________

Name of the Insured: ______________________________________ Is the insured a patient? [ ] Yes [ ] No

Last First M.I.

Insured's Birth Date: _______________________________ ID#: ______________ Group#: _______________________

Insured's Employer Name: ____

Insurance Name and Address: ____

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Secondary Insurance:

Patient's relationship to insured: [ ] Self [ ] Spouse [ ] Child [ ] Other ____________________________

Name of the Insured: ______________________________________ Is the insured a patient? [ ] Yes [ ] No

Last First M.I.

Insured's Birth Date: _______________________________ ID#: ______________ Group#: _______________________

Insured's Employer Name: ____

Insurance Name and Address: ____

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CONSENT FOR SERVICES

- I hereby authorize doctor of designated staff to take x-rays, study models, photgraphs and other diagnostic aids deemed appopriate by doctor to make a thorough diagnosis of the patient's dental needs.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that the use of such medications embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- I agree to be responsible for payment of all services rendered on my behalf of my depenents. I understand that payment is due at the time of sevice unless prior arragements are made.
- I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I also understand that a check of my credit history may be made.
- I have read the above conditions of treatment and agree to their content.

Patient/guardian Signature ____ **Date** ____________________

Patient's Name (printed) ____

Dentist Signature ____ **Date** ____________________