The Khisti Dental Center

PATIENT INFORMATION

Patient Name________________________________ SS#________________

Last First MI

Birth date________________ Age______ Sex: M F

Circle appropriate: Single Married Widowed Separated Divorced

Address____

Street City State Zip

Home Phone #__________ Work Phone #__________ Cell Phone #__________ E-Mail__________

Occupation______________ Employer________________ Phone #______________

Spouse's Name________________ Do you have children? Yes No How Many?________

If minor, parent or guardian name________________ Parent/Guardian Employer________________

How did you hear about us? ____

Emergency Contact: Name________________________ Relationship________________

Home Phone #______________ Work Phone #______________ Cell Phone #______________

DENTAL INSURANCE INFORMATION

Insurance Company________________ Group #________________ Telephone #______________

Subscriber's Name________________________ Subscriber's Employer________________________

Birth date______________ SS/ID #______________ Relationship to Patient________________

Is patient covered by additional insurance? Yes No If yes, please provide necessary information to staff member.

MEDICAL INFORMATION

Physician Name________________________________ Phone #________________

Are you under the care of a physician (other than for routine physicals)? Yes No

Are you in good health? Yes No Date of last physical exam________________

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

If yes, what condition is being treated?____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes No

If yes, what was the illness or problem?____

Are you taking or have recently taken any prescription or over the counter medicine(s)? Yes No

If yes, please list all (including vitamins, natural or herbal preparations and/or diet supplements) on the ***attached form.***

PATIENT MEDICAL HISTORY

Check if you have or have had any of the following:

___ Anesthesia Allergy

___ Allergies, Other

____

___ Anemia/Hemophilia

___ Arthritis/Rheumatism

___ Artificial Heart or Valves

___ Asthma

___ Autoimmune Disease

___ Bacterial Endocarditis

___ Blood Disease/Disorder

___ Blood Transfusion

___ Cancer/Leukemia

___ Chemical Dependency (alcohol or drug)

___ Chemotherapy

___ Chronic Pain

___ Circulatory Problems

___ Codeine Allergy

___ Congenital Heart Defects

___ Congestive Heart Failure

___ Cough, Persistent or Bloody

___ Diabetes

___ Eating Disorder

___ Emphysema/COPD

___ Epilepsy

___ Excessive Urination

___ Fainting/Seizures

___ Gastrointestinal Disease

___ GE Reflux/Persistent Heartburn

___ Glaucoma

___ Headaches or Migraines (frequent or severe)

___ Heart Attack

___ Heart Disease

___ Heart Murmur

___ Heart Surgery/Stents

___ Hepatitis Type___

___ High Blood Pressure

___ HIV/AIDS

___ Hypoglycemia

___ Jaundice

___ Latex Allergy

___ Liver Disease

___ Low Blood Pressure

___ Metal Allergy

___ Osteoporosis/Osteopenia

___ Pacemaker

___ Peanut Allergy

___ Penicillin Allergy

___ Persistent Swollen Neck Glands

___ Psychiatric Care/Problems

___ Radiation

___ Severe or Rapid Weight Loss

___ Sexually Transmitted Disease

___ Sinus Trouble

___ Skin Rash/Hives

___ Stomach Problems

___ Stroke

___ Swollen Feet or Ankles

___ Systemic Lupus

___ Taking Blood Thinners

___ Tetracycline Allergy

___ Thyroid Problems

___ Tuberculosis

___ Tumor or Growth on Head or Neck

___ Ulcer

Do you have any disease, condition, or problem not listed above that you think we should know about? Yes No

Please explain: ______________________________

Are you taking or scheduled to begin any bisphosphonate or similar medication for osteopenia, osteoporosis, bone disease, or metastatic cancer (I.V. or oral)? Yes No

Do you use tobacco (smoking or smokeless)? Yes No

Any Joint Replacement-Have you had hip, knee, shoulder, elbow, or finger replacement? Yes No Date: ______________

WOMEN ONLY

Are you pregnant? Yes No Number of weeks__________ Nursing? Yes No Taking birth control pills? Yes No

DENTAL HISTORY (For New Patients)

Reason for visit ____

Name of previous dentist ______________________ Phone # ______________

Date of last dental visit ______________________ Last dental x-rays ______________

Are you satisfied with the appearance of your teeth? Yes No

Please explain: ____

Would you like to change the appearance of your teeth? Yes No

Please explain: ____

Have you ever been advised that any dental treatment is necessary that has not yet been accomplished?

Yes No

Check if you have any of the following:

____Do your gums bleed while brushing or flossing?

____Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?

____Do you feel pain in any of your teeth?

____Have you noticed any loosening of your teeth?

____Does food tend to become caught between your teeth?

____Do you have any sores or lumps in or near your mouth?

____Do you clinch or grind your teeth while awake or asleep?

____Have you had any head, neck or jaw injuries?

____Have you ever had any difficult extractions or prolonged bleeding?

____Have you ever had an upsetting dental experience?

____Is there anything about having dental treatments that bothers you?

If so, please explain ______________________________

____Do you bite your lips or cheeks frequently?

____Do you wear dentures or partials?

Have you ever experienced any of these jaw problems?

____Clicking

____Pain (joint, ear, side of face)

____Difficulty in chewing

____Difficulty opening or closing

Have you ever had?

____Orthodontics (braces)

____Oral Surgery

____Periodontal or Gum Treatment

____Teeth ground or bite adjusted

MEDICATIONS

Patient Name____ **Date**____________________

Please list any *PRESCRIPTION* or *OVER THE COUNTER* medications you are currently taking. This includes vitamins, herbal, dietary and sexual enhancement drugs. Include the dosage, frequency taken and reason for taking medication.

DRUG	DOSAGE	FREQUENCY	REASON TAKING

POS® Reorder # 1418003

Khisti Dental Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, ______________________________ have received a copy of this office's Notice of Privacy Practices.

Please Print Name ____________ Signature ____________ Date ____________

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information as indicated below*

ANY MEMBER OF MY IMMEDIATE FAMILY	____YES	____NO
OTHER (Specify)	____YES	____NO
______________________	____YES	____NO
______________________	____YES	____NO
______________________	____YES	____NO

*Failure to check any individual box does not constitute permission, consent, or authorization to disclose my personal health information. Each item of authorization must be signed or otherwise acknowledged.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign ___ Communication barrier prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement ___ Other (specify) ____________

Khisti Dental Center

Informed Consent of Dental Treatment

Dentistry to be Performed:

I consent to allow the doctor and/or clinical staff to obtain all necessary diagnostic information, such as radiographs (x-rays), as needed in order to reach a diagnosis of my condition. I understand that the doctor will visually examine my mouth and I will be asked to review all benefits, pertinent risks and alternatives to proposed treatment. My financial responsibility will be identified and I acknowledge that it will be my responsibility to pay these fees when treatment is started. My signature on the treatment will be acknowledgement that all this information has been presented to me, that I understand the proposal and that I consent to start treatment as listed.

Please Initial________________________________

Changes During Treatment:

I understand that during treatment it may be necessary to change or add procedures because of conditions which were not evident during the initial examination. If such change or addition should occur the doctor will discuss the benefits, pertinent risks and alternatives, then ask for my initials or signature and date as consent of the changes prior to continuing.

Please Initial________________________________

Anesthesia or Medication:

I understand that I may require injections of local anesthesia, the use of nitrous oxide or may be prescribed antibiotics and/or analgesics. These medications can cause unusual or allergic reactions, including, but not limited to: nausea, swelling, pain, itching, tissue irritation, respiratory problems, prolonged muscle soreness, prolonged numbness of the lips or tongue, accidental tongue or lip biting while numb, or drowsiness. If I suffer any of these symptoms I will contact the doctor immediately for evaluation of my symptoms. I do voluntarily assume the possible hazards and risks as mentioned above and any possible side effects not mentioned and do agree to hold harmless The Khisti Dental Center, the doctors and staff.

Please Initial________________________________

Basic Restorations (Fillings):

I understand that The Khisti Dental Center does not use or offer the silver amalgam material for restorations. I understand that if my insurance carrier provides a lesser alternate benefit for silver amalgam restorations, I will be responsible for the difference between the silver amalgam and the composite resin (white, tooth colored material) restoration fee.

Please Initial________________________________

Crowns, Bridges, and Cosmetic Procedures:

I understand that I will be wearing a temporary crown, which may come off easily and that I must be careful to ensure that it is kept on until the permanent crown is cemented. I will be shown the final restoration before it is permanently installed. If I wish any changes, I must inform the doctor prior to cementation or give consent for the permanent cementation of the restoration. If I choose porcelain or bonded acrylic restorations, which are subject to chewing force, I understand that the restoration may fracture when I chew or it may prematurely wear down my opposing teeth and that The Khisti Dental Center, will not be responsible for any of these consequences and it will be my responsibility to pay additionally for any rendered subsequent services. I understand that once I have accepted the final restoration, and the doctor has permanently cemented it, any further changes or replacement will be at an additional expense. I understand that the potential complications include, but are not limited to: tooth nerve death which would necessitate root canal treatment or tooth extraction, recession of the gum tissue surrounding the tooth which may create an adverse cosmetic result, and the inability to match the color or shape of the adjacent or opposing natural teeth.

Please Initial________________________________

Signature of Patient (or Parent/Guardian if minor): ________________________ Date: ____________

Doctor Signature: ________________________ Date: ____________

Witness Signature: ________________________ Date: ____________

Office, Dental Insurance and Financial Policies

Dear Patient:

Thank you for choosing The Khisti Dental Center for your dental needs. We would like to acquaint you with our policies regarding dental insurance, schedule changes, etc. We always strive to maintain quality dentistry with compassion in a comfortable and friendly atmosphere. We hope that you and your family feel welcome to our dental family.

Since we know it is not always possible to pay your dentist bill in full, we would like to explain our financial options. Payments may be made by cash, check, VISA, MasterCard, Discover, or American Express. There will be a $35.00 charge for any returned checks. Please choose the option that works best for you.

- Dental Insurance- If you have dental insurance, as a courtesy to you, we will file electronically with all the necessary information and submit it to the insurance company. We ask that you pay the estimated expense at the time services are rendered. The co-pay is an estimated amount based on the information that is provided to us. Once we submit the claim, the amount may vary and you will be responsible for the difference.
- Monthly Payments- If you need to make long-term payments we can offer financing with Care Credit. You must qualify to use this option.

FOR SEPARATED OR DIVORCED PARENTS, OUR POLICY IS THAT A PARENT WHO BRINGS THE CHILD TO THE OFFICE FOR TREATMENTS IS RESPONSIBLE FOR PAYMENT OF THE CHARGES.

All patients with an outstanding balance will receive a statement each month. We reserve the right to apply a billing charge of 2% per month (APR 24%) on all accounts 60 days past due.

**We reserve the right to charge for broken appointments which include those broken without 24-hrs. notice, 48-hrs. for sedation cases, and 72-hrs. for appointments scheduled on Mondays. The cost for a broken appointment is $50.00.

SIGNIFICANT EXPOSURE-Section 32.1-45,1(A) and (B), code of Va. (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis virus is considered to have been given the patient and/or healthcare worker thereby granting the Hospital the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of a local hospital.

I authorize and release information and payment of my dental insurance to the dentist. I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill including co-pays, deductibles, or non-covered services requested by me. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees at 33 1/3%, court costs, interest (and any other charges that incurred to collect this account) on the principal balance of 18% per annum from date of service.

Signature of patient (or Parent/Guardian if minor) ______________________

Date ______________________