Appt. Day: _____ Date: _____/_____ Time: _____ DR. _____

ACCOUNT INFORMATION

Title: _____ First Name: _____ Last Name: _____

Please provide us with your home address and requested phone numbers:

c/o: _____ Home Phone: ( )- _____

Street: _____ Business Phone: ( )- _____

City: _____ State: _____ Zip: _____

Please Provide us with the name of your employer and Dental Insurance Co.:

Employer: _____ Insurance CO.: _____

c/o: _____ c/o: _____

Address: _____ Address: _____

_____ _____

Social Security #: _____ Birthdate: _____

Email: _____

Driver's License #: _____ Credit Card #: _____

Emergency Contact: _____ Phone: ( )- _____

Who told you about our practice? _____

Is there dental insurance coverage by another family member? Y N

PATIENT INFORMATION

First: _____ Last: _____

Patient's Address:

c/o: _____

Address: _____

_____

Is the patient over 18? Y / N Ortho? Y / N Insurance? Y / N Medicaid? Y / N

Sex: _____ Birthdate: _____ Phone: ( )- _____

Email: _____

Prime DENTAL
DARSHNA MODY, DDS

PATIENT HIPAA CONSENT FORM

Personally identifiable information about your health, your health care, and your payment for health care is called Protected Health Information. We must safeguard your PHI and give you this Notice about our privacy practices that explains how, when, and why we may use or disclose your PHI. Except in the situations set out in the Notice, we must use or disclose only the minimum necessary Protected Health Information to carry out the use or disclosure.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

_____ I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

_____ I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the effective date of revocation is not affected.

1. Prime Dental may call the number listed on file regarding my treatment.	YES	NO
2. Prime Dental may leave detailed messages on my voicemail regarding treatment.	YES	NO
3. Prime Dental may email the email on file regarding treatment.	YES	NO
4. Prime Dental may contact a family member regarding my treatment.	YES	NO

If **YES**, please list the family member(s):

Name: _____ Number: _____

Signature: _____ Date: _____

Prime DENTAL
DARSHNA MODY, DDS

Patient Agreement and Financial Policy

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE.

Payment Options:

1. Cash
2. Mastercard
3. Visa
4. Discover

Unfortunately, at this time we do not accept checks.

Patients with insurance: The PATIENT is responsible for the *ESTIMATED* non-covered portion, procedures and/or deductibles at the time of service.

Patients without insurance are FULLY responsible for any payments regarding diagnostic and treatment services. These payments are due at the time of service.

Parents accompanying their child(ren) are fully responsible for their copayment.

Parents not accompanyingtheir child must make **PRIOR** arrangements for payment.

While we strive to provide the **MOST** accurate information possible, please keep in mind that it is an ***ESTIMATE***. By signing I agree that if the insurance company does not reimburse PRIME DENTAL and its doctors, I am**FULLY** responsible for the total cost of services rendered.

I, _____, agree to these financial terms explained in this agreement.

Signature: _____ Date:_____

CANCELLATION POLICY

ATTENTION PATIENTS: NEW POLICY STARTING 06/2024

Prime Dental requires 24-hour cancellation notice for ALL scheduled appointments. Failure to do so may result in a **$25 cancellation fee**, which must be paid **prior** to *rescheduling your appointment*.

By signing this form, you are acknowledging the new cancellation policy and accepting responsibility.

Signature: _____ Date: _____

Prime DENTAL

DARSHNA MODY, DDS

Did you know? *The ADA recognizes the use of fluoride as safe and effective in preventing tooth decay for both children and adults?*

Facts about fluoride:

1. Fluoride is a mineral that occurs naturally in water and many foods.
2. Fluoride is recommended every 3, 6, or 12 months depending on your oral health.
3. Fluoride can't remove decay, but with regular treatments it can help stop the decay from penetrating into deeper parts of your teeth.

Fluoride Benefits:

1. Re-mineralizes tooth enamel.
2. Reverses early decay.
3. Slows down the process of demineralization.
4. Prevents growth of cavity causing bacteria.

The American Dental Association (ADA) highly recommends fluoride for people with any of the following:

- History of decay
- Areas of sensitivity
- Crowns, Bridges, Partials
- Areas of recession
- Patients receiving radiation therapy
- Poor diet
- Dry mouth

Some dental insurances will cover fluoride treatments for children and adults. Each insurance is different, and coverage varies. Regardless of coverage, preventative services like fluoride treatments can reduce the cost of dental services in the future and save money in the long run.

☐ I would like to have fluoride treatment
☐ I do not want to get fluoride treatment

Signature: _____ Name: _____

Date: _____

DATE:_____/_____/_____ PATIENT NAME:____________________________________ BIRTHDATE____/____/____

PHYSICIAN"S NAME:____ DATE OF LAST PHYSICAL:____/____/____

PHYSICIAN"S PHONE:(_____)______________________ ADDRESS:____

DOES THE PATIENT HAVE, OR HAS THE PATIENT EVER HAD, ANY OF THE FOLLOWING:

HEART PROBLEMS	YES____	NO____	ANEMIA	YES____	NO____
HEART MURMURS	YES____	NO____	ARTHRITIS	YES____	NO____
RHEUMATIC FEVER	YES____	NO____	ASTHMA	YES____	NO____
HIGH BLOOD PRESSURE	YES____	NO____	DIABETES	YES____	NO____
LOW BLOOD PRESSURE	YES____	NO____	ULCERS	YES____	NO____
CIRCULATORY PROBLEMS	YES____	NO____	KIDNEY DISEASE	YES____	NO____
EXCESSIVE BLEEDING	YES____	NO____	LIVER DISEASE	YES____	NO____
STROKE	YES____	NO____	SEIZURES	YES____	NO____
A SHUNT	YES____	NO____	NERVOUS PROBLEMS	YES____	NO____
AN INTERNAL PROSTHESIS	YES____	NO____	PSYCHIATRIC CARE	YES____	NO____
BLOOD TRANSFUSION	YES____	NO____	MALIGNANCIES	YES____	NO____
MEASLES	YES____	NO____	RADIATION TREATMENTS	YES____	NO____
MUMPS	YES____	NO____	ALLERGIES TO ANESTHETICS	YES____	NO____
SCARLET FEVER	YES____	NO____	ALLERGIES TO MEDICATIONS	YES____	NO____
TYPHOID FEVER	YES____	NO____	ALLERGIES TO ANYTHING	YES____	NO____
HEPATITIS	YES____	NO____	ARE YOU PREGNANT	YES____	NO____
(YELLOW) JAUNDICE	YES____	NO____	ANY PHYSICAL HANDICAPS	YES____	NO____
TBERCULOSIS	YES____	NO____	RECENT SEVERE WEIGHT LOSS	YES____	NO____
SICKLE CELL ANEMIA	YES____	NO____	EXTREME FATIGUE	YES____	NO____
TONSILLITIS	YES____	NO____	NIGHT SWEATS	YES____	NO____
SINUS PROBLEMS	YES____	NO____			

PLEASE LIST ANY ALLERGIES____

DO YOU HAVE OR HAVE YOU BEEN IN CONTACT WITH AIDS .... YES____ NO____

HAVE YOU HAD ANY RECENT HOSPITALIZATIONS .... YES____ NO____

IF SO, EXPLAIN____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS .... YES____ NO____

IF SO, EXPLAIN____

HAVE YOU HAD ANY PROBLEMS WITH PAST DENTAL TREATMENT .... YES____ NO____

IF SO, EXPLAIN____

IS THERE ANYTHING ELSE IN YOUR MEDICAL OR DENTAL HISTORY THAT MAY POSSIBLY AFFECT YOUR DENTAL TREATMENT .... YES____ NO____

IF SO EXPLAIN____

SIGNATURE:________________________________ RELATIONSHIP________________________________

(OVER PLEASE)

(OVER PLEASE)

FOR OFFICE USE ONLY:

PREMEDICATION NEEDED? YES_________ NO _________ SPECIFY________________________________

REVIEWED BY:

SIGNATURE: ____

REVIEW MEDICAL HISTORY:DATE_________, PATIENT (PARENT)____________________________, FOR PD__________

REVIEW MEDICAL HISTORY:DATE_________, PATIENT (PARENT)____________________________, FOR PD__________

REVIEW MEDICAL HISTORY:DATE_________, PATIENT (PARENT)____________________________, FOR PD__________

REVIEW MEDICAL HISTORY:DATE_________, PATIENT (PARENT)____________________________, FOR PD__________

REVIEW MEDICAL HISTORY:DATE_________, PATIENT (PARENT)____________________________, FOR PD__________

REVIEW MEDICAL HISTORY:DATE_________, PATIENT (PARENT)____________________________, FOR PD__________

REVIEW MEDICAL HISTORY:DATE_________, PATIENT (PARENT)____________________________, FOR PD__________