

Date: _____

PATIENT INFORMATION

Patient Name: _____
(Last) (First) (MI) (Preferred Name)

Gender: _____ Family Status: _____

Social Security Number: _____ Birth Date: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Which number can we best reach you? _____

Employer: _____ Occupation: _____

E-mail: _____

Address: _____

(Street)

(City)

(State)

(Zip Code)

Do you have dental insurance? ___YES ___NO

If yes, please allow us to scan your card.

HEALTH INFORMATION

Please circle if any of the following conditions apply:

Do you have, or have you ever had the following:

- | | | | |
|-------------------|---------------------|---------------------|-------------------------------------|
| AIDS | EXCESSIVE BLEEDING | KIDNEY DISEASE | STROKE |
| ALLERGIES | FAINTING | LIVER DISEASE | TUBERCULOSIS |
| ANEMIA | GLAUCOMA | MENTAL DISEASE | TUMORS |
| ARTHRITIS | GROWTHS | NERVOUS DISORDERS | ULCERS |
| ARTIFICIAL JOINTS | HAY FEVER | PACEMAKER | VENERAL DISEASE |
| ASTHMA | HEAD INJURIES | PREGNANCY | BONE DENSITY DRUGS |
| BLOOD DISEASE | HEART DISEASE | RADIATION TREATMENT | (such as Boniva, Fosamax, etc) |
| CANCER | HEART MURMUR | RHEUMATIC FEVER | BLOOD THINNERS |
| DIABETES | HEPATITIS | RHEUMATISM | (such as aspirin, Coumadin, Plavix) |
| DIZZINESS | HIGH BLOOD PRESSURE | SINUS PROBLEMS | OTHER CONDITIONS: |
| EPILIEPSY | JAUNDICE | STOMACH PROBLEMS | _____ |
| | | | _____ |

Please list all medications you are taking:

Please list all drug allergies:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Patient Signature _____ Date: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: ___ the patient's spouse ___ the person responsible for payment

Name: _____ Male: ___ Female: ___

Social Security Number: _____ Birth Date: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Address: _____

(Street)

(City)

(Zip Code)

Employer: _____ Occupation: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections form insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ percent per month (18 percent per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to , by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you and your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

(signature of patient, parent or guardian)

(date)

(relationship to patient)

(signature of guarantor of payment/responsible party)

(date)

(relationship to patient)

NOTICE OF PRIVACY ACT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out the following: 1) Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment 2) Obtaining payment from third party payers (e.g. my insurance company) 3) The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Private Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

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 date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: **Manisha Desai Patel, DDS**

Address: **224 Talbert Road**

City/State/Zip: **Mooresville, NC 28117**

