

# PERSONALIZED DENTAL CARE PLLC

Cheryl Bologna D.D.S. & Amit Batra D.D.S.

Name: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

Your Employer: \_\_\_\_\_ Phone (Work): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Your Position: \_\_\_\_\_

Are You: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_  
Position: \_\_\_\_\_ Phone (Work): \_\_\_\_\_

Name of PRIMARY Dental Insurance: \_\_\_\_\_  
Subscribers Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Group No. \_\_\_\_\_ Policy No. \_\_\_\_\_ Service Code: \_\_\_\_\_  
Is there a SECONDARY Insurance? Y / N  
Subscribers Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Group No. \_\_\_\_\_ Policy No. \_\_\_\_\_ Service Code: \_\_\_\_\_

## Your Dental Health History

Are you experiencing any discomfort at this time? **Y / N** Where? \_\_\_\_\_  
When was your last dental checkup and cleaning? \_\_\_\_\_  
Have you had a full mouth set of x-ray's within 5 years? \_\_\_\_\_  
How often do you see the dentist? \_\_\_\_\_  
Have you lost any permanent teeth? \_\_\_\_\_  
Do you wear any removable appliances? \_\_\_\_\_  
Are your teeth sensitive to: Hot? \_\_\_\_\_ Cold? \_\_\_\_\_  
How often do you brush your teeth? \_\_\_\_\_  
Do you use floss? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you have bleeding gums? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you use a flouride rinse? \_\_\_\_\_ How often? \_\_\_\_\_  
Have you ever had gum treatments? \_\_\_\_\_  
Have you ever had your teeth straightened? \_\_\_\_\_  
Would you ever consider adult orthodontics? \_\_\_\_\_

\*\*\*PLEASE COMPLETE OTHER SIDE\*\*\*

**Medical History**

**Do you have any of the following? PLEASE PUT A "Y" OR "N" NEXT TO EACH**

<input type="checkbox"/> Heart problems	<input type="checkbox"/> Seasonal allergies	Has anyone ever told you that you snore? _____
<input type="checkbox"/> High blood pressure Is it monitored? Y / N What was your last reading? _____	<input type="checkbox"/> Allergies to anesthetics? Which ones: _____ _____	
<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Allergies to medications? Which ones? _____ _____	Have you been diagnosed with insomnia? _____ when? _____
<input type="checkbox"/> Hepatitis when _____	<input type="checkbox"/> Do you smoke or use smokeless tobacco?	
<input type="checkbox"/> Stroke when _____	<input type="checkbox"/> Do you grind your teeth? If yes, do you wear an appliance? _____	Do you use a CPAP or oral device? _____ type? _____
<input type="checkbox"/> Rheumatic Fever when _____		
<input type="checkbox"/> Sinus problems		
<input type="checkbox"/> HIV / AIDS		

Other:(please describe) \_\_\_\_\_

**Has any doctor ever told you that you need to Pre-Medicate with an antibiotic before dental procedures due to a medical condition? YES / NO :If YES, what condition? \_\_\_\_\_**

Do you take vitamin supplements? \_\_\_\_\_

Are you taking ANY medications? YES / NO - List **ALL** medications and what they are for:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WOMEN:** Are you pregnant? YES / NO – Are you currently taking birth control? YES / NO

Do you feel you have a healthy diet? \_\_\_\_\_

Is your diet monitored by a physician? \_\_\_\_\_

What treatment do you expect to receive today? \_\_\_\_\_

Is there any special dental treatment you'd like us to know about? \_\_\_\_\_

**Who may we thank for referring you to our office? \_\_\_\_\_**

**Emergency Contact (Not living with you)**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

**Consent for Treatment**

I authorize the doctors, hygienists, and staff of Personalized Dental Care to examine, and if necessary x-ray and treat any found dental conditions with my knowledge and consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Financial Policy

## Personalized Dental Care PLLC

Our philosophy is to make our patients lives healthier and more comfortable by providing *High Quality, Compassionate, Personalized* Dental Care PLLC.

We at Personalized Dental Care are committed to providing you with the best possible dental care. To do this, it is important that we do not allow your dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your dental needs. We assume that you are as concerned as we are about maintaining your excellent dental health.

Due to many changes in insurance policies, it is no longer an easy task to interpret each patient's individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, please be aware that it is the patient's responsibility to know your coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs.

As a courtesy to our patients, we will bill your insurance carrier for any services rendered. However, we do require that any uncovered services, deductibles, or co-payments be paid in full at each appointment. Co-payments are estimated based on the information we have obtained from your insurance carrier. We do not guarantee any estimates and should your plan pay or state less than expected, you are fully responsible. We take no responsibility for any denials by dental plans.

In addition, to avoid any confusion or misunderstandings, the following simply states our financial policy regarding payment for professional services.

- Payment is due, in full, as treatment is rendered. Cash, check, Visa, MasterCard and Discover card are accepted forms of payment.
- Payment plans are available through our program with Care Credit. Interest free and extended terms are available. Please ask our office for more information or an application.
- Any Parent/Guardian that brings a minor in for professional services must accept all financial responsibility.
- There is a service charge on all returned checks.
- A fee will be charged for excessive missed appointments.
- Any account balance that goes unpaid for 90 days or more will be turned over to a collection agency, and additional administrative fees will be applied to all accounts turned over for collections.

***I have read and understand the financial policy outlined above. In addition, I understand that my failure to comply with this policy may result in my account being turned over for collections.***

X \_\_\_\_\_

Signature of Patient, Parent/Guardian

\_\_\_\_\_ Date



**PERSONALIZED DENTAL CARE PLLC**

**Cheryl A. Bologna D.D.S**

**Amit Batra D.D.S.**

Acknowledgement of Receipt of Practice's Privacy Notice

I acknowledge that I have received, and/or reviewed the notice of the Privacy Practices of this office. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that this notice of the Privacy Practices is posted in the office where I can review it if desired.

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Patient or Patient Representative

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Date

If patient representative signs above, please describe the relationship to the patient.