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

___Heart problems

___High blood pressure

Is it monitored? **Y / N**

What was your last reading?____

___Circulatory problems

___Hepatitis

when _____

___Stroke

when _____

___Rheumatic Fever

when _____

___Sinus problems

___HIV / AIDS

___Seasonal allergies

___Allergies to anesthetics?

Which ones: _____

_____

___Allergies to medications?

Which ones? _____

_____

_____

___Do you smoke or use smokeless tobacco?

___Do you grind your teeth?

If yes, do you wear an appliance?____

Has anyone ever told you that you snore? _____

Have you ever had a sleep study? _____ when?_____ where?_____

Have you been diagnosed with insomnia? _____ when? _____

Have you been diagnosed with sleep apnea? ____ when? _____

Do you use a CPAP or oral device? _____ type? _____

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**