Sweta Tailor, DDS, PLLC.

Patient Information

Please Print

Date: _____

Name: _____
First Middle Initial Last

Address: _____
Street Apt City State Zip

Home Phone: _____Work Phone: _____Cell Phone: _____

Sex: M ___ F ___ Birth Date: _____ SS#: _____

E-mail address _____

Marital Status: M___ S___ Name of Spouse: _____

Person to notify in case of emergency: _____ Phone #: _____

Employer (University / School if Student):_____

Whom may we thank for referring you? _____

If the patient is a minor, responsible parents' names: _____

Insurance Information

Dental Insurance Carrier: _____ Phone #: _____

Policyholder(name):_____ Policyholder's Phone #: _____

Policyholder I.D. # (or SSN):_____

Policyholder's Date of Birth:_____ Group or Plan #:_____

Relationship to policyholder (Check): Self ☐ Spouse ☐ Dependent ☐ Other ☐ _____

Dental History

Former Dentist:_____

Reason for today's visit: _____

Date of last exam: _____ Date of last dental x-rays: _____

Please check any of the following conditions that apply to you:

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Grinding teeth
☐ Loose teeth
☐ Periodontal treatment
☐ Dry mouth
☐ Sensitivity to hot/cold/sweet
☐ Broken filings
☐ Sensitivity when biting
☐ Previous Orthodontic work

(Continue on back)

Office Policies

Please read, initial each section, and sign below.

_____PAYMENT: Payment in full is expected at the time services are rendered. We accept cash, checks, MasterCard, VISA, Discover, and CareCredit. A returned check fee of $30.00 will be assessed for any check payment that is returned due to insufficient funds. Subsequently, payment options for patients or accounts with returned items may be limited to cash or credit card.

_____DENTAL INSURANCE: If we agree to accept assignment of benefits from a dental insurance company, patients must pay for any portion of the charges not covered as services are rendered. If payment for any dental claim is not received within 45 days, you will receive a statement for the entire balance due. If payment is not made within 45 days of receipt of the statement, your account may be turned over to collections. Charges that are denied or not covered by the insurance company are the responsibility of the patient or guardian.

_____COLLECTION COSTS: Account balances more than 45 days past due may be sent to collections. Patients will be responsible for costs of collections including, but not limited to, collection agency fees, attorney fees and court costs.

_____PATIENT AND INSURANCE INFORMATION: The patient will be responsible for informing the office of any changes to the following: mailing address, phone numbers, emergency contact information, insurance plan information, and changes in medical history, including the list of medications you are currently taking.

_____BROKEN APPOINTMENTS: A missed appointment or late cancellation charge of $35/hour will be assessed for any appointment that is missed with the hygienist, and $50/hour missed with the dentist for any appointment that is cancelled with less than 48 hours notice.

_____HIPAA: I have reviewed and/or received a copy of the office's Notice of Privacy Practices.

_____QUESTIONS: Open communication is an important part of ongoing treatment and is essential if we are to keep you well informed and happy with our services. If you have any questions regarding your bill or dental treatment, please ask for clarification or additional information.

By signing below, I acknowledge that I have read, understood, and agree to the above office policies. I also understand that I am ultimately financially responsible for any balance on my account.

Signature: _____ Date: _____

Medical History

Name:_____ **Date:**_____

Primary Care Physician (medical): _____ Phone #:_____

Please list all medications you are currently taking: 1)_____

2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____

8)_____ 9)_____ 10)_____

Allergies to medications: _____

Allergy to latex: ☐ Yes ☐ No

(Women) Are you pregnant? Yes ☐ Due Date:_____ No ☐ Nursing? Yes ☐ No ☐

Are you taking birth control pills/hormone replacement therapy? Yes ☐ No ☐

Please check if you have ever or now have any of the following:

☐ AIDS / HIV	☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease
☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis A / B (circle)	☐ COPD
☐ Arthritis, Rheumatism	☐ Congenital Heart Disease	☐ Hepatitis C	☐ Emphysema
☐ Artificial Heart Valve	☐ Cough - persistent, or	☐ Herpes	☐ Shortness of Breath
☐ Artificial Joint (circle)	with blood	☐ High Blood Pressure	☐ Stroke
Knee / Hip	☐ Diabetes	☐ Immunosuppresive Drugs	☐ Chemical Dependency
Other:_____	☐ (Family History)	☐ Infective Endocarditis	☐ Swelling of feet/ankles
☐ Asthma	☐ Epilepsy / Seizures	☐ Intestinal Disorder	☐ Thyroid Problems
☐ Auto Immune Illness	☐ Fainting/Dizziness	☐ Kidney Disease	☐ Tobacco Habit
☐ Back Problems	☐ Glaucoma	☐ Dialysis	☐ Tuberculosis
☐ Blood Disease	☐ Heart Attack	☐ Kidney Transplant	☐ Ulcers
☐ Cancer	☐ Heart Problems:	☐ Liver Disease	☐ Venereal Disease
☐ Chemotherapy	_____	☐ Nervous Problems	☐ Psychiatric Care
☐ Radiation Treatment	☐ Heart Surgery	☐ Pace Maker	☐ Headaches (chronic)
☐ Surgery	☐ Heart Transplant	☐ Parkinson's	☐ Bisphosphonate Medication (for bones)

Please list any other medical conditions that we should be aware of:_____

_____

Are you under the care of a specialist for any of these conditions? Yes ☐ No ☐

Name of Specialist (If 'yes'):_____ Phone:_____

To the best of my knowledge, all of the preceding information provided is true and complete. If I ever have any change in my health, I will inform the doctors at the next appointment.

_____ Date: _____