CHITRA P. NAIK,DMD,PLC
G-4007 W. COURT ST. STE.A
FLINT MI 48532
(810) 235-5422

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this offices Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices , but acknowledgement could not be obtained because:

A. Individual refused to sign

B. Communication barriers prohibited obtaining the acknowledgement

C. An emergency situation prevented us from obtaining acknowledgement

D. Other (Please Specify) _____

_____

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU – THANK YOU

PATIENT LAST NAME _____ **FIRST** _____ **INITIAL** _____

How do you wish to be addressed? _____ DOB _____

(❑ Single ❑ Married ❑ Divorced) (❑ Male ❑ Female) Full time Student? ❑ Yes ❑ No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

Is patient covered by another dental insurance? ❑ Yes ❑ No Insurance Co. _____

How did you hear about our practice? Whom may we thank for your referral? _____

HUSBAND, FATHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

WIFE, MOTHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

NEAREST RELATIVE

Last Name _____ First _____ Initial _____

Address _____

City _____ State _____ Zip _____ E-Mail _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

PATIENT REGISTRATION

PLEASE COMPLETE ALL INFORMATION – THANK YOU!

PATIENT LAST NAME _____ PATIENT FIRST NAME _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

	No	Yes
Bad Breath	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on one side of mouth	☐	☐
Cigarette, pipe or cigar smoking	☐	☐

	No	Yes
Dry mouth	☐	☐
Food collection between teeth	☐	☐
Clench or grind teeth	☐	☐
Growths or sore spots in your mouth	☐	☐
Gums swollen, tender or bleeding	☐	☐

	No	Yes
Head, neck or jaw pain or aches	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐
Orthodontic treatment	☐	☐

	No	Yes
Nitrous Oxide (laughing gas)	☐	☐
Periodontal treatment	☐	☐
Sensitivity to pressure or irritants (cold, heat, sweets)	☐	☐
Smokeless tobacco	☐	☐

How often do you floss? _____ How often do you brush? _____

Have you ever had an allergic reactions to Novocaine, local or general anesthetics? No ☐ Yes ☐ _____

Have you had trouble from previous dental care? No ☐ Yes ☐ _____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____

Have you had any serious illnesses or operations No ☐ Yes ☐ If yes, please describe _____

Have you ever had a blood transfusion No ☐ Yes ☐ If yes, give approximate dates _____

(Women) Are you pregnant? No ☐ Yes ☐ Due date _____ Nursing? No ☐ Yes ☐ Taking birth control pills? No ☐ Yes ☐

	No	Yes
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Required Hospitalization	☐	☐
Have you used steroids	☐	☐
Date of last episode _____	☐	☐
Bleeding abnormally with operations or surgery	☐	☐
Blood disease, clotting disorders	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐

	No	Yes
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis Type _____	☐	☐
Herpes	☐	☐

	No	Yes
High blood pressure	☐	☐
Any Immune Deficiency	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Liver disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Radiation treatments	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐

	No	Yes
Sickle cell anemia	☐	☐
Skin rash	☐	☐
Slow healing wounds	☐	☐
Stroke	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tonsilitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head or neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐
Weight loss, unexplained	☐	☐
Do you wear contact lenses?	☐	☐
Do you consume alcoholic beverages?	☐	☐

Are you currently under the care of a physician? No ☐ Yes ☐

Allergy to Penicillin, Aspirin or Other Drugs or Latex No ☐ Yes ☐ Specify: _____

List any medications you are currently taking:

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above question to the best of my knowledge

Patient/Guardian Signature _____ Date _____

Reviewed by: _____ Date _____

CHART L3

DENTAL & MEDICAL HEALTH HISTORY