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

Financial Policy and Agreement

Insurance:

As a courtesy to our patients, we will gladly file the forms necessary to see that your received the full benefits of your dental coverage. We ask that you read your policy to be fully aware of any limitations of the benefits provided. **Please note: Many plans have frequency limitations pertaining to a number of the procedures done in our office. These limitations may change from benefit year to benefit year. If you are concerned about coverage for these services, please contact your insurance company prior to your visit.**

If your insurance company denies coverage, or we otherwise do not receive payment 30 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and /or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay.

Estimates:

Our practice software enables us to estimate your insurance benefits after the dentist has identified any necessary treatment. In cases where extensive dental treatment is recommended, we will submit a preauthorization to your insurance company for an estimate of the dental benefits. Regardless of estimated insurance coverage, any fees incurred for services received, will be your financial responsibility.

Your Payment is Due at the Time of Treatment:

The estimated uninsured portion of your dental treatment is due at the time of service.

Financial Arrangements:

Because we realize that every person's financial situation is different, we provide a variety of payment options.

Payment Options:

For your convenience, the following options are available:

- Cash or check (returned checks will be subject to a $30 returned check fee. If the check Is returned for any reason, your account becomes due and payable within 7 days.)
- For your convenience, we have made arrangements to accept payment by Visa, MasterCard, and Debt Cards.
- Care Credit- Care Credit is accepted and applications are available in our office or online.

C

Appointment/Cancellations:

We gladly reserve appointment times for you and as a courtesy, will attempt to remind you of your appointment by calling 2 days prior to confirm your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and /or reschedule you appointment. We reserve the right to charge a fee of $40.00 for appointments cancelled or broken without 24 hour notice.

Patient/Parent/Guardian Responsibility:

I understand that whoever accompanies my child to their dental appointment has authorization to consent to dental care as needed, and is responsible for payment of dental services.

I acknowledge my responsibility for payment of all dental services provided by Dr. Chitra P. Naik, D.M.D. in accordance with their fees and terms.

In the case where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment. They may then seek reimbursement from the other parent.

Assignment and Release:

I authorize payment to be made directly to the dentist by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any dental care information requested by my insurance company.

My signature below acknowledges that I have read and understand this information.

Patients/Parent/Guardian Signature:_____

Name Printed:_____

Relationship to Patient:_____Date:_____