DR. DUDHAT & ASSOCIATES
We make you smile

abingtondmd@yahoo.com
www.abingtondmd.com
215-881-8551

Abington Dental Excellence
1130 Old York Road
Abington, PA 19001

PATIENT INFORMATION

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: (Street/Apt.) _____ (City) _____ (St) _____ (Zip) _____

SS#: _____ Birth Date: _____ Sex: _____ Marital Status: Minor( ) Single ( ) Married ( )

Phone No: (H) _____ (W) _____ Separated ( ) Divorced ( ) Widowed ( )

Additional Phone/Cell No: _____ Student? _____ Full-time ( ) Part-time ( )

Spouse/Parent's Name: _____ Email: _____

Are any of your family members our patients? (Yes/No) _____ If Yes, Who? _____

How did you hear about us? _____

Previous Dentist's Name and Phone No.: _____

Last Dental Visit (Date): _____

PRIMARY DENTAL INSURANCE

Name of Insurance Co.: _____ Phone No.: _____

Subscriber's Name: _____ Date of birth _____ Relationship: _____

Employer's Name: _____ SS No./ID No.: _____ Group No.: _____

SECONDARY DENTAL INSURANCE

Name of Insurance Co.: _____ Phone No.: _____

Subscriber's Name: _____ Date of birth _____ Relationship: _____

Employer's Name: _____ SS No./ID No.: _____ Group No.: _____

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Physician's Name: _____ Phone No.: _____

YES	NO	
____	____	Are you having any pain or discomfort at this time?
____	____	Have you ever had a full mouth x-rays taken of your teeth? If yes, when? _____
____	____	Have you ever had treatments for your gums?
____	____	Do your gums hurt or bleed when you brush?
____	____	Do your teeth hurt when you chew?
____	____	Have you ever been aware of a bad odor or taste in your mouth?
____	____	Are your teeth sensitive to hot, cold or sweet?
____	____	Do you clench or grind your teeth during day or night?
____	____	Do you ever wake up from sleep due to shortness of breath?
____	____	Have you ever had orthodontic treatment or worn braces?
____	____	Are you on a special diet?
____	____	Do you use a tobacco products? What and how much _____
____	____	Do you use controlled substances? How much _____ How often _____
____	____	Have you been a patient in the hospital during the past two years? For what _____
____	____	Have you been under the care of a medical doctor in past years? For what _____

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FOR WOMEN ONLY

_____ _____ Are you now or think you may be pregnant?
_____ _____ Are you nursing?
_____ _____ Are you presently taking birth control pills?

THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

Are you **Allergic or have your reacted adversely** to any of the following medications?

_____ **Aspirin**	_____ **Erythromycin**	_____ **Percodan**	_____ **Sulfa**
_____ **Codeine**	_____ **Local Anesthetic**	_____ **Penicillin**	_____ **Tetracycline**
_____ **Darvon**	_____ **Scopolamine**	_____ **Valium**	
_____ **Demerol**	_____ **Nitrous Oxide**	_____ **Sleeping Pills**	

Other, if yes, please explain: _____

Check any of the following you have had or have at present:

_____ AIDS (HIV)	_____ Diabetes	_____ Mitral Valve Prolapse (MVP)
_____ Arthritis	_____ Emphysema	_____ Nervousness/Irregular Heartbeat
_____ Asthma	_____ Epilepsy or Seizures	_____ Pacemaker
_____ Angina Pectoris	_____ Fainting or Dizzy Spells	_____ Pain in Jaw Joints
_____ Artificial Heart Valve	_____ Genital Herpes	_____ Psychiatric Care
_____ Anemia	_____ Glaucoma	_____ Rheumatic Fever
_____ Artificial Joints	_____ Heart Disease or Attack	_____ Rheumatism
_____ Allergies or Hives	_____ High Blood Pressure	_____ Radiation Treatment
_____ Bruise Easily	_____ Heart Murmur	_____ Renal Dialysis
_____ Blood Transfusion	_____ Heart Pace Maker	_____ Sinus Trouble
_____ Cancer	_____ Hay Fever	_____ Sickle Cell Disease
_____ Congenital Heart Disorder	_____ Hepatitis A	_____ Stroke / Swelling of limbs
_____ Cold Sores/ Fever Blisters	_____ Hepatitis B or C	_____ Scarlet Fever
_____ Cough/Frequent Cough	_____ Hemophilia	_____ Thyroid Disease
_____ Cortisone Medicine	_____ Herpes	_____ Tuberculosis (TB)
_____ Chemotherapy	_____ Kidney Problems	_____ Tumors or Growths
_____ Drug Addiction	_____ Liver Disease	_____ Ulcers
_____ Chest pains	_____ Leukemia	_____ Venereal Disease
_____ Parathyroid Disease	_____Lung Disease	_____ Yellow Jaundice

List any other condition not listed above: _____

Dr's. Signature: _____ Date: _____
Dr's. Signature: _____ Date: _____
Dr's. Signature: _____ Date: _____
Dr's. Signature: _____ Date: _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill of services. I agree to be responsible for payments for all services rendered on my behalf or my dependents. The dentist agrees to consider the amount paid as a participating provider from the participating insurance companies.

X_____Date: _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

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DENTAL OFFICE INFORMED CONSENT

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may, with your agreement, perform. We want to involve you in all decisions concerning invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is a risk associated with dental procedures, and all your questions have been answered.

Dental treatment and procedures are not to be taken for granted as being routine or without risk for complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are potentially many variables, some predictable and others are not. Complication rates in dentistry are low but do exist. Even a minor procedure like "filling" can lead to major complications that cannot be foreseen. For example, **"Novacaine"** injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. These are fairly granted uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These kinds of complaints can be transient or may persist requiring further treatments. The above examples are some samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems.

I have read, understand and consent to dental treatments. INITIALS: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are required to pay for services as rendered. We accept cash, Visa, MasterCard, American Express and Discover or Debit/ATM cards. We offer an In-House Membership Plan. We offer 3% courtesy on the prepayment of *Patient-Doctor discussed treatment* plans. We offer up to 12 months **INTEREST-FREE** financing payment plans.

OFFICE POLICY

When you make an appointment we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. **We reserve the right to charge for any appointment(s) broken without a 48 hours notice. The charge will be $35.00. Checks returned from the bank are subject to a $40.00 service fee.**

Accounts delinquent more than 30 days from the date of billing are subject to a 1.5% per month (12% annually) finance charge. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

We welcome you to our office and want to provide you with the best dental care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED CONSENT AND FINANCIAL POLICIES.

Signature: _____ Date: _____

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OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your dental treatment being successful. We agree in writing with every patient to sign our financial policy, as we have found with our past experience that this policy makes our mutual experience easier and without confusion. This policy is to ensure that all of our patients receive a highest level of quality dental care in a friendly and healthy environment while understanding their financial responsibilities. This policy as well as other health and insurance forms provided must be read, agreed to, and signed prior to any dental treatment.

Cash Patients
Patients with no insurance are expected to pay in cash, check or credit card the day the service is rendered, unless specific arrangements are made in advance OR getting our ***CUSTOMIZED MEMBERSHIP PLAN.***

Insurance Patients
For those patients covered by insurance, we may accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Very few insurance policies cover 100% of the cost of your treatment. In this day and age many cover 50% or less on many services and actually cover nothing on others. Due to this, and the frequent delays in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will estimate as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. Some patients request that we send in a pre-determination to their insurance carriers. We state what treatment you need, and they tell us what they will cover on that treatment plan. Many patients prefer to get service started immediately, and some treatments should be started immediately. In these cases we will ask you to pay for your services in full as they are done (For an example: RCT, Implant placement), and when the insurance company pays their portion we will reimburse you for what they pay. ***We will help you in dealing with the insurance company, but ultimately the responsibility of payment and insurance problems lies with you.*** If we do accept assignment of benefits from the insurance company, if the insurance company hasn't paid after 30 days, the full balance is expected from you personally.

The above policies apply equally to parents and guardians of minors being treated, and minors cannot be treated without a parent or guardian authorizing treatment and agreeing to financial responsibility. Thank you for reading and understanding our financial policy. If you have any questions or concerns; please feel free to ask them at any time. We wish to be of assistance in any way we can.

Sincerely,

Dr. _____

I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED FINANCIAL POLICIES.

_____ Date: _____
Signature of responsible party

_____
Please print your name

FINANCIAL ARRANGMENT VIA AUTHORIZATION TO CHARGE CREDIT/DEBIT CARD:

I, _____, give permission for Dr. _____ to charge the remaining balance of $ _____ not to exceed, $ _____ after insurance payment. I understand that I am responsible for all charges regardless of the outcome of my insurance claim. Card # _____ Exp: _____

Amount to be charged: $ _____
Insurance payment received: $ _____
Balance charged to credit card: $ _____

❖ **WE OFFER DENTAL WARRANTY & STAND BEHIND ON OUR DENTAL TREATMENT. PLS. ASK DOCTORS FOR DETAILS.**

END