ATCHISON FAMILY DENTISTRY

413 S. 10th Street | Atchison, KS 66002 | (913) 367-0203
DentistinAtchison.com | AtchisonFamilyDental@gmail.com

AMISH PATEL, DDS

PATIENT INFORMATION

Chart # ________

Last name :: ______________________ First name :: ______________________

Preferred name :: ______________________ Social Security # :: ______ – _____ – ______

Middle initial :: _____ Gender :: ☐ Male ☐ Female Family status :: ☐ Married ☐ Single ☐ Child ☐ Other

Birthdate :: ____________ Date of last visit :: ____________

Home Phone Number :: ______________________ Mobile Phone Number :: ______________________

Work Phone Number :: ______________________ Other Phone Number :: ______________________

Best Time to Call :: ____________ ☐ AM ☐ PM Email address :: ______________________

Address 1 :: ______________________ Address 2 :: ______________________

______________________ ______________________

City :: ______________________ City :: ______________________

State :: ______ Zip :: ____________ State :: ______ Zip :: ____________

I agree to receive communications regarding my appointments and/or treatment plan via ::

☐ Email ☐ Text ☐ Voicemail

Please enter Employer and Occupation information ::

____

____

Whom may we thank for referring you to our practice?

____

____

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DENTAL HISTORY INFORMATION

Chart # ________

What is the reason for your visit today? ______________________________

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist's Name : : ______________________________

Previous Denist's Office phone number : : ______________________________

Date of most recent dental exam and dental X-rays : : ______________________________

I routinely see my dentist every : :

☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had or have braces (orthodontic treatment)
- ☐ Have dry mouth
- ☐ Teeth are sensitive to hot, cold, biting or sweets
- ☐ Food gets trapped between any teeth
- ☐ Have whitened or bleached your teeth
- ☐ Have popping and/or clicking of your jaw joint
- ☐ Have difficulty chewing
- ☐ Clench or grind your teeth
- ☐ Wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Have been treated for gum disease
- ☐ Have or had gum recession
- ☐ Had an unpleasant taste or odor in your mouth
- ☐ Have or had a burning sensation in your mouth
- ☐ Snore or wake up frequently during the night
- ☐ Would like to change the appearance of my smile
- ☐ Dental anxieties

If any of the checked boxes need further explanation, please describe : : ______________________________

____

____

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INSURANCE

Chart # ________

INFORMATION FOR THE INSURED

First Name : : ____________ Last Name : : ____________ Middle Initial: : __

Address : : ____________________________________

City : : ____________ State : : ______ Zip : : ______

Patient's relationship to the insured : : ☐ Self ☐ Spouse ☐ Child ☐ Other : : ______

If you have secondary dental insurance, please present your insurance card to the front desk at the time of your appointment.

INSURED'S EMPLOYER INFORMATION

Insured's Employer Name : : ____________________________________

Employer Address : : ____________________________________

City : : ____________ State : : ______ Zip : : ______

INSURANCE INFORMATION

Insurance Plan Name : : ____________________________________

Address : : ____________________________________

City : : ____________ State : : ______ Zip : : ______

Phone Number : : ____________ Plan ID Number : : ____________ Group Number : : ____________

INSURANCE AUTHORIZATION

☐ **By checking this box, I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.**

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PATIENT APPOINTMENT AGREEMENT & HIPAA

Chart # ________

PATIENT APPOINTMENT AGREEMENT

In order to accommodate requests for appointments from every new, existing and emergency patient and to ensure that we have providers in the practice to accommodate these requests, we ask you to give our practice a minimum of 48 hours notice if you realize you will be unable to keep your scheduled appointment. We will not charge for missed appointments. However, after one missed appointment, you will be assessed a $50 reservation fee when scheduling the next appointment. If you keep the appointment, the reservation fee will be applied towards treatment. However, if you fail to keep the appointment, the reservation fee will be forfeited. Our commitment to excellence is delivered through our high clinical standards as well as our appointment management guidelines. Thank you for agreeing to support our appointment policy.

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for this Administration Form.**

HIPAA ACKNOWLEDGEMENT

_____ I understand that I may inspect or copy the protected health information described by this authorization.

_____ I understand that ay any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

_____ I understand that information used to disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ I authorize this office to disclose or discuss my personal and/or dental information with the following person(s):
Name :: ________________________________ Relationship to Patient :: ________________

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

____

Patient or Responsible Party's Signature | Printed Name | Date

Relationship to Patient :: ☐ Self ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Legal guardian ☐ Other

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CONSENT FOR SERVICES & FINANCIAL POLICY

Chart # ________

_____ As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

_____ All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed unless other arrangements are made.

_____ Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

_____ A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

_____ I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

_____ In consideration for all the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

____

Patient or Responsible Party's Signature　　Printed Name　　Date

Relationship to Patient : :　☐ Self　☐ Parent　☐ Step-parent　☐ Grandparent　☐ Legal guardian　☐ Other

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RESPONSIBLE PARTY

Chart # ________

PERSON RESPONSIBLE FOR ACCOUNT

Please indicate the responsible party:

☐ I am financially responsible for this account : : *Skip this section and continue to next section*

☐ Other : : *Please fill out information below.*

The following is for: ☐ Patient's Spouse ☐ Person responsible for payment ☐ Both ☐ Neither / Not Applicable

INFORMATION FOR RESPONSIBLE PARTY

Last name : : ____________________ First name : : ____________________

Preferred name : : ________________ M.I. : : ____ Social Security # : : ______ – ____ – ______

Gender : : ☐ Male ☐ Female Birthdate : : ________ Family status : : ☐ Married ☐ Single ☐ Child ☐ Other

Home Phone Number : : ________________ Mobile Phone Number : : ________________

Work Phone Number : : ________________ Other Phone Number : : ________________

Best Time to Call : : __________ ☐ AM ☐ PM Email address : : ________________

Address : : ____

____

City : : ______________________ State : : ____ Zip : : ________