Welcome to our office. Please take a few moments to complete this form so that we may provide you with the finest care available. If you have any questions, please do not hesitate to call us. 703-686-4343

Today's Date: _____/_____/_____

PATIENT INFORMATION

First Name: _____ Middle: _____ Last Name: _____

Preferred Name: _____ SSN: _____-_____-_____ Birthdate: _____/_____/_____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work: (_____) _____

Email: _____

Sex: M or F Status: Married _____ Single _____ Widowed _____ Divorced/Separated_____

Person to contact in case of an emergency: _____ Phone: (_____) _____

RESPONSIBLE PARTY

First Name: _____ Middle: _____ Last Name: _____

Preferred Name: _____ SSN: _____-_____-_____ Birthdate: _____/_____/_____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work: (_____) _____

Email: _____ Relationship to Patient: _____

_____**(INITIALS)** I hereby authorize assignments of my insurance rights and benefits to Jatinder Kaler, DMD, PC for services rendered. I fully understand I am solely responsible for any balance unpaid by my insurance company.

INSURANCE INFORMATION

Name of Insured: _____ Relation to Patient: _____

Birthdate: _____/_____/_____ SSN: _____-_____-_____ Insured's ID: _____

Insured's Employer: _____Work Phone: (_____) _____Group Number: _____

Employer Address: _____City: _____ State: _____ Zip: _____

Insurance Company: _____Phone: (_____) _____

Address: _____City: _____ State: _____ Zip: _____

WHOM MAY WE THANK FOR REFERRING YOU

__ *Clipper Magazine*
__ *Facebook*
__ *Friend/Relative:* _____
__ *Google*
__ *Website (www.kaydentalcare.com)*
__ *Yelp*
__ *Other (Please Specify):* _____

PREFERRED METHOD OF CONTACT

___ *Phone*
___ *E-mail*
___ *Mail*

BP:	P:

Health Information

KAY DENTAL CARE TAKES YOUR ORAL HEALTH VERY SERIOUSLY, BUT BEFORE WE START YOUR TREATMENT. WE NEED SOME BRIEF INFORMATION ON YOUR MEDICAL HISTORY. YOUR MEDICAL HISTORY MAY AFFECT DENTAL TREATMENT. **ALL INFORMATION IS CONFIDENTIAL**.

Patient's Name: _____ Date of Birth: _____Last Physical Date: _____

Physician's Name &Phone #: _____

Reason for today's visit? _____ Work Related Injury? **YES NO**

Have you been under the care of a physician? **YES NO** Have you been hospitalized? **Yes NO**

Date of Last Dental Visit: _____ Date of last dental X-rays: _____

Date of last cleaning: _____ Have you ever been treated for periodontal (gum) disease: **YES NO**

Ever had Novocain or other local anesthetic? **YES NO** Are you interest in tooth whitening? **YES NO**

If wearing dentures, age of dentures: _____ Are you interested in new dentures: **YES NO**

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? **YES NO**

Are you taking or have taken oral Bisphosphonates, IV Bisphosphonates, ACTONEL, AREDIA, AVASTIN, BONIVA, , FOSAMAX , NEXAVAR, PROLIA, RAPAMUNE, RECLAST, SUTENT, XGEVA, ZOMETA,? **YES NO** Taken for how long? _____

Have you taken antibiotics prior to dental procedures in the past? **YES NO**

Have you had a adverse reaction or become ill to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? **YES NO**

List any medications you are **allergic** to:

1. _____ 2._____ 3. _____ 4. _____

List any **medications you are taking** including non-prescription drugs including herbals/vitamins:

1. _____ 2._____ 3. _____ 4. _____

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth sores/growths		
Diabetes			Aspirin/Anticoagulant Therapy			Ulcers / Stomach Problems			Teeth Grinding/Clenching		
Pacemaker/Heart Surgery			Venereal Disease			Arthritis			Pain in your jaw (TMJ)		
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Any type of implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Any type of Transplant		
Heart Problems ( )			Excessive Bleeding			Cancer (Type)			Any Artificial Hip, Knee, etc.		
Stroke			Hepatitis (Type)			Chemotherapy			Other Disease or Illness:		
Lung Disease			Liver Disease			Radiation Treatment					
Breathing Problems			Kidney Disease			Use of Tobacco Products					
Tuberculosis (TB)			Dialysis			Drug Addiction					

Women	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date: ____/____/____			Are you taking birth control prescriptions?		
NOTE: Antibiotic (Such as penicillin) may alter the effectiveness of birth control pills. Consult your Physician for assistance regarding additional methods of birth control.					

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Patient's/Guardian's Signature: _____ Date: _____ Dr.'s Signature: _____ Date: _____

Patient's/Guardian's Signature: _____ Date: _____ Dr.'s Signature: _____ Date: _____

Patient's/Guardian's Signature: _____ Date: _____ Dr.'s Signature: _____ Date: _____

Appointment Cancellation Policy Agreement:

We will now be charging $50 for broken/No show appointments without 24 hours' notice. Please keep in mind that we do not double book appointments so that we can devote the time we set aside to each of our patients individually. This allows us to keep wait times short. It is hard for us to continue with this philosophy if patients do not show up for their scheduled appointments, leaving big holes in our schedule that could have been given to someone else. We always do our best to call and confirm appointments a few days in advance as a reminder; however, we cannot always reach you. If you know you will not be able to attend a scheduled appointment, please contact us and we would be happy to reschedule for you.

Please sign below to consent to these terms.

X_____ _____

Client Signature (Parent/Guardian if under 18) Date

Acuerdo Politica De Cancelacion De Citas:

Comprendemos que hay veces que no va poder acudir a la cita con su doctor. Les pedimos de favor que llame a nuestra oficina con un aviso de 24 horas. Esto nos proporciona poder ofrecer esta cita a otro paciente. Nuestra oficina mantiene su cita con el tiempo necesario para su tratamiento. Si usted no avisa y no se presenta a su cita será cargardo **$50** adicionales. Recuerde que este cargo no puede ser cobrado a su compañía de seguro.

Por favor firme abajo para dar su consentimiento a estos términos.

X_____ _____

Firma Del Cliente (padre/tutor si es menor de 18 años) Fecha

GENERAL DENTISTRY INFORMED CONSENT FORM

1. **EXAMINATION AND X-RAYS:** I understand that the initial visit may require radiographs to complete the examination, diagnosis, and treatment plan. Pictures may also be taken for insurance and lab purposes.

2. **DRUGS, MEDICATION, AND SEDATION:** I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased using alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. **CHANGES IN TREATMENT PLAN :** I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions, as necessary.

4. **TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

5. **FILLINGS**: I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

6. **REMOVAL OF TEETH (EXTRACTION):** Alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved is having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

7. **CROWNS, BRIDGES, VENEERS AND BONDING:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge, or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. **DENTURES – COMPLETE OR PARTIAL:** I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

9. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

10. **PERIODONTAL TREATMENT:** I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

CONSENT: *I understand that dentistry is not an exact science, therefore: reputable practitioner cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.*

Signature: _____ Date: _____

1. **Notice of Privacy Practices (must be signed by ALL new patients).**

By signing below, I acknowledge that I have read Kay Dental Care's Notice OF Privacy Practices, as mandated by Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature: _____ **Date**: _____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below.)

2. **Payments, Insurance and Financial Arrangement Policies (must be signed by ALL new patients).**

By signing below, I agree to the terms of the Kay Dental Care "Financial Policy" document.

Signature: _____ **Date**: _____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below.)

3. **Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance).**

To the extent of the permitted law, I cogent to Kay Dental Care 's use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to Kay Dental Care of the dental benefits otherwise payable to me.

Signature: _____ **Date:** _____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below.)

Responsible Party (If patient is under 18 or disabled)
Circle One: Dr./Mr./Mrs./Ms./Miss

First: _____ Middle: _____ Last: _____ Jr/Sr:_____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient SSN: _____-_____-_____ Patient DOB: ____/____/_____ Sex: **M** or **F**

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have been made aware of the office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

To Whom can the Office share Protected Health Information

Name_____ Relationship_____ Phone # _____

Name_____ Relationship_____ Phone # _____

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:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

_____