gentle dental CARE

1809 Vestal Parkway E. Vestal, Ny 13850
(607) 785-1900

ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

☐ Male ☐ Female

Birthdate: _____ Age: _____ SS#/ID# _____

Home Address _____
APT/CONDO#

_____
CITY STATE ZIP

Home #: _____ Cell# _____

Wk# _____ Ext# _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best time to reach you? _____

_____

Who may we **Thank** for referring you? _____

Other family members seen by us: _____

_____

In case of an emergency, who should we contact?

_____

SPOUSE/PARTNER INFORMATION

Their Name: _____

Relationship: _____

Address (If different): _____

_____

Employer: _____

Wk# _____ Ext. ____ Cell# _____

Birthdate: _____

Person responsible for Account: _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone# _____

ID# _____ Group # _____

Insured's Name: _____ Relation: _____

Insured's Birthday: _____ Insd's SS# _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone# _____

ID# _____ Group # _____

Insured's Name: _____ Relation: _____

Insured's Birthday: _____ Insd's SS# _____

Insured's Employer: _____

MEDICAL HISTORY

Physician's Name: _____

Phone#: _____ Date of last visit: _____

Please list all the medications you are currently taking:

_____

_____

_____

_____

_____

MEDICAL HISTORY

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out ttlls Questionnaire.

	YES	NO		YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐	Are you PREGNANT? (for Females)	☐	☐
Are you under a PHYSICIAN'S CARE	☐	☐	Do you SMOKE?	☐	☐

For what? _____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

☐ Heart Disease Or Attack	☐ Stroke	☐ Epilepsy or Seizures	☐ Hay fever
☐ Angina Pectoris	☐ Kidney Trouble	☐ Nervousness	☐ Sinus Trouble
☐ High Blood Pressure	☐ Ulcers	☐ Psychiatric Treatment	☐ Allergies or Hives
☐ Heart Murmur	☐ A.I.D.S./A.R.C./HIV Positive	☐ Glaucoma	☐ Diabetes
☐ Rheumatic Fever	☐ Hepatitis A (infectious)	☐ Chemotherapy (Cancer. leukemia)	☐ Thyroid Disease
☐ Congenital Heart Lesions	☐ Hepititis 8 (serum) t	☐ Venereal Disease	☐ Radiation Treatment
☐ Mitral Valve Prolapse	☐ Liver Disease	☐ (Syphlis, Gonorrhea. etc.)	☐ Arthritis
☐ Artificial Heart Valve	☐ Blood Transfusion	☐ Bruise Easily	☐ Cortisone Medicine
☐ Heart Pacemacker	☐ Drug Addiction	☐ Emphysema	☐ Pain in Jaw Joints
☐ Heart Surgery	☐ Hemophilia (Bleeding Problems)	☐ Tuberculosis (T8)	☐ Alcoholism
☐ Artificial Joints (Hip. Knee)	☐ Fever Blister	☐ Asthma	☐ Cosmetic Surgery
☐ Anemic	☐ Cocaine or other recreational drugs (local anesthetic may cause CARDIAC ARREST If using cocaine)		

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATION?

Y N Aspirin	Y N Local Anesthetic	Y N Erythromycin	Y N Latex
Y N Nitrous Oxide	Y N Codeine	Y N Penicillin	Y N _____ Any other substances

Y N Do you need to take pre-medication of antibiotics before dental treatment?

If yes. please list: _____

Is there any other Medical or Dental information that you feel I should know about? _____

DENTAL HISTORY

	YES	NO		YES	NO
HOW LONG SINCE you have seen a Dentist?			Do you have HEADACHES. EARACHES, or NECK PAINS?	☐	☐
Last COMPLETE Dental Exam. Date:			Have your worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Last FULL MOUTH X-RAYS. Date: (16 small Films or Panoramic)			Do you have DISCOLORED teeth that bother you?	☐	☐
Are you having PROBLEMS now?	☐	☐	Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
WHAT?			Do you REGUIARLY use DENTAL FLOSS?	☐	☐
Is your Present dental health POOR?	☐	☐			
Do you wear DENTURES? (Partials or full)	☐	☐	Name of Previous Dentist:		
Are you UNHAPPY with your dentures?	☐	☐			
Would you like to know more about PERMANENT REPLACEMENTS?			City: State:		
	☐	☐			
Are you APPREHENSIVE about dental treatment?	☐	☐	How do you feel about your teeth?		
Have you had any PERIDONTAL (GUM) treatments?	☐	☐	*RANK the following in the order in which they would KEEP YOU FROM having dental treatment.*		
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐	_____ FEAR	_____ LACK of concern	
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (CIRCLE ONE)			_____ COST of treatment	_____ MISSING work time	
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐			
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐			

CONSENT

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is A CONTRACT between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor for my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a finance charge will be added to any overdue balance. Should this account go to collection or an attorney, I agree to pay all reasonable charges.

Patient signature or Legal Guardian _____ Date: _____

Sanjay Kamodia, DDS
Shalini Kamodia, DDS
gentle dental
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Acknowledgement of receipt of Notice of HIPAA (privacy) Practices

I have received a copy of this office's Notice of Privacy Practices.

I authorize Gentle Dental Care, Dr. Sanjay Kamodia, and its employees and associates to disclose my health information according to The Standard Authorization of Use and Disclosure of Protected Health Information. The information covered by this authorization includes dental records, medical records including but not limited to radiographs, pathology or biopsy results, past or current medications, and all information pertaining to delivery of health care by our office. Information may be disclosed to dental labs, insurance carriers or financial entities contracted for payments, other health care providers such as dentists, medical doctors, pharmacies, nursing homes and home health care agencies and our legal representatives. This authorization is effective indefinitely unless revoked or terminated by the patient or the patient's representative. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Your Insurance and Your Responsibilities

We are pleased that you have insurance, and will gladly assist you in whatever way possible to receive the maximum benefits available in your plan for any treatment you may incur in our office. However, please be advised that the contract is between you, your employer, and your insurance company. We are not a part to that contract.

As a courtesy to you, we will confirm benefits with your insurance carrier, and based on the information we receive, we will estimate your out of pocket investment. However, in no way should this estimate be considered a guarantee of payment. Actual benefits will be determined by your insurance company when your claims are processed.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry our any payment activities in connection with my claims as well as my dental treatments.

I herby authorize direct payment of the dental benefits to Dr. Sanjay Kamodia, Gentle Dental Care. I also authorize Dr. Sanjay Kamodia, Gentle Dental Care to charge my credit card for any outstanding balance not covered by my insurance carrier or any balance not paid by me within 90 days. A $20 per month financing/billing charge may apply thereafter.

Credit Card#_____Expiration_____Security Code_____

Signature of Patient or Representative_____**Date**_____

Thank you for choosing our office! We look forward to a long and mutually rewarding relationship. Please do not ever hesitate to let us know if we can do anything to help make your visits here more comfortable.