

**Pankaj Narkhede, DDS, MDS, F-ISMU & FAAID(Honored)**  
**24602 Raymond Way, Suite L, Lake Forest, CA 92630**  
**949-770-0966**

DATE: \_\_\_/\_\_\_/\_\_\_

**PATIENT INFORMATION**

NAME \_\_\_\_\_  MARRIED  SINGLE  MINOR  MALE  FEMALE  
 LAST FIRST M

ADDRESS \_\_\_\_\_  
 STREET APT# CITY STATE ZIP

BIRTHDAY \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
 MONTH DAY YEAR HOME CELL WORK **EMAIL (for newsletters & office communications ONLY)**

I will accept official Text Messages from this office YES / NO Cell # \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_

IF FULL TIME STUDENT, SCHOOL NAME \_\_\_\_\_ GRADE \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE  PARENT  GUARDIAN  SPOUSE  FATHER  MOTHER

**INSURANCE INFORMATION**

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCK FOR PATIENT INFORMATION.  
 ADULTS – COMPLETE PRIMARY INSURED  
 DUAL COVERAGE ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED/ IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY	SECONDARY INSURANCE
LAST FIRST M.	LAST FIRST M.
STREET WORK # FAX# EMAIL#	STREET WORK # FAX# EMAIL#
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT	BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER	EMPLOYER
SS# SUBSCRIBER# GROUP#	SS# SUBSCRIBER# GROUP#

**PERSON TO CONTACT IN CASE OF EMERGENCY**  
 OUTSIDE OF IMMEDIATE FAMILY HOUSEHOLD

NAME \_\_\_\_\_ Relation: \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 TELEPHONE # \_\_\_\_\_

**AUTHORIZATION**

I hereby authorize and request the performance of dental services for myself or for \_\_\_\_\_ Age \_\_\_\_\_.

I also give my consent to any advisable and necessary dental procedures, medication or anesthetics to be administered; perform diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care by the attending dentist or by the supervised staff for diagnostic purpose or dental treatment.

I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named regardless of insurance coverage. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or health professionals.

X \_\_\_\_\_  
 Patient or Responsible party

State \_\_\_\_\_ State Driver's License # \_\_\_\_\_

Has any member of your family ever been treated in our office?  
 Yes  No

**Whom we may thank for referring you to our office?**

**METHOD OF PAYMENT**

Responsible patient currently has an account with this office  
 Yes  No  
 Payment in full at each appointment (cash or personal check)  
 Payment in full at each appointment ( VISA  MC  OTHER)

Card # \_\_\_\_\_ Exp Date \_\_\_\_\_

**SERVICE CHARGE**

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or minimum charge of \$3.00 for a balance under \$200.00), which is at an annual percentage rate of 12.5%, applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and attorney fees incurred to effect collection of this account or future outstanding accounts.

# DENTAL AND MEDICAL HISTORY UPDATES

**Pankaj Narkhede, DDS, MDS**  
 24602 Raymond Way, Suite L, Lake Forest, CA 92630  
 949-770-0966

PATIENTS NAME \_\_\_\_\_ DATE \_\_\_\_\_

Primary reason for this dental appointment: Examination Emergency Second Opinion Referred by CA health dept. Other

## DENTAL HISTORY

Do you have a specific dental problem? Describe \_\_\_\_\_ Yes No  
 Do you have dental examination on a routine basis? Last visit \_\_\_\_\_ Yes No  
 Do you have migraine headaches? Discuss \_\_\_\_\_ Yes No  
 Do you ever have clicking, popping or discomfort in the TMJ? Do you Brux or grind? \_\_\_\_\_ Yes No  
 Are you aware that your TMJ / Bite problems may cause headaches \_\_\_\_\_ Yes No  
 Do you like your smile? Why? \_\_\_\_\_ Yes No  
 Have your past experience in a dental office always been positive? \_\_\_\_\_ Yes No  
 Do you smoke or chew? Any sores or growths in your mouth? Discuss \_\_\_\_\_ Yes No  
 Name of previous dentist (optional) \_\_\_\_\_ Yes No

## MEDICAL HISTORY

Are you under a physician's care now? Why? \_\_\_\_\_ Who? \_\_\_\_\_ Phone \_\_\_\_\_ Yes No  
 Have you ever been hospitalized or had a major operation? Discuss \_\_\_\_\_ Yes No  
 Have you ever had a serious injury to your head or neck? Discuss \_\_\_\_\_ Yes No  
 Are you taking any specific medications, pills or drugs? What? \_\_\_\_\_ Yes No  
 Ever taken fen-phen? \_\_\_\_\_ Yes No  
 Are you on a special diet? Discuss \_\_\_\_\_ Yes No

**Are you allergic to any medication or substances?** Yes No **If Yes, Please check box below**

Aspirin Penicillin Codiene Acrylic Metal Latex Rubber Other \_\_\_\_\_

Women (please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives? Discuss \_\_\_\_\_

**Do you now or have you ever had any of the following? Please check appropriate boxes.**

if yes to any of the starred conditions, please call prior to your appointments....premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/ Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemophillia (bleeding problems)	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker*	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained fever	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray treatment (for cancer/other)	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Medicines)	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Pollen/Dust)	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint*	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes No

Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change. I shall inform the dentist and staff at the next appointment without fail.

X \_\_\_\_\_ Date \_\_\_\_\_ Reviewed by Dr. Narkhede \_\_\_\_\_

## MEDICAL UPDATES

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	BP	REVEIWD BY
_____	_____	None <input type="checkbox"/> _____	_____	Dr. Narkhede
_____	_____	None <input type="checkbox"/> _____	_____	Dr. Narkhede
_____	_____	None <input type="checkbox"/> _____	_____	Dr. Narkhede

**Pankaj Narkhede, DDS, Inc.**

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949-770-0966

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

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

\_\_\_\_\_  
{Please Print Name}

**X**

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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**For Office Use Only**

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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 situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

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**SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Pankaj Narkhede

Telephone: 949-770-0966 Fax: 949-770-2899 E-mail: [pnarkhede5@aol.com](mailto:pnarkhede5@aol.com)

Address: 24602 Raymond Way, Ste L, Lake Forest, Ca 92630

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

**If this Consent is signed by a personal representative on behalf of the patient, complete the following:**

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include completed Consent in the patient's chart.**

**REVOCAION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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