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

PATIENT INFORMATION

DATE:____/_____/_____

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 # _____

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

Whom we may thank for referring you to our office?

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 #

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

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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	☐	☐	Hemophillia (bleeding problems)	☐	☐	Frequent Diarrhea	☐	☐	HIV Positive	☐	☐
Heart Murmur*	☐	☐	Leukemia	☐	☐	Diabetes	☐	☐	Genital Herpes	☐	☐
Irregular Heart Beat	☐	☐	Recent Blood Transfusion	☐	☐	Excessive Thirst	☐	☐	Drug Addiction	☐	☐
Angina/Chest Pain	☐	☐	Swelling of Limbs	☐	☐	Hypoglycemia	☐	☐	Cold Sores	☐	☐
Heart Attack/Failure	☐	☐	Lung Disease	☐	☐	Liver Disease	☐	☐	Fever Blisters	☐	☐
Congenital Heart Disorder	☐	☐	Breathing Problems	☐	☐	Hepatitis A (infectious)	☐	☐	Herpes	☐	☐
Mitral Valve Prolapse*	☐	☐	Shortness of Breath	☐	☐	Hepatitis B or C	☐	☐	Stroke	☐	☐
Scarlet Fever	☐	☐	Frequest Cough	☐	☐	Night Sweats	☐	☐	Convulsions	☐	☐
Rheumatic Fever*	☐	☐	Hay Fever	☐	☐	Yellow Jaundice	☐	☐	Epilepsy or seizures	☐	☐
Artificial Heart Valve*	☐	☐	Sinus Trouble	☐	☐	Kidney Problems	☐	☐	Fainting or Dizziness	☐	☐
Heart Pace Maker*	☐	☐	Asthma	☐	☐	Renal Dialysis	☐	☐	Glaucoma	☐	☐
Heart Surgery	☐	☐	Bloody Sputum	☐	☐	Thyroid Disease	☐	☐	Tumors or Growths	☐	☐
High Blood Pressure	☐	☐	Emphysema	☐	☐	Parathyroid Disease	☐	☐	Nervousness	☐	☐
Low Blood Pressure	☐	☐	Tuberculosis	☐	☐	Arthritis/Gout	☐	☐	Psychiatric Care	☐	☐
Blood Disease	☐	☐	Cancer	☐	☐	Rheumatism	☐	☐	Alzheimer's Disease	☐	☐
Unexplained fever	☐	☐	X-Ray treatment (for cancer/other)	☐	☐	Pain in Jaw Joints	☐	☐	Allergies (Medicines)	☐	☐
Bruise Easily	☐	☐	Chemotherapy	☐	☐	Cortisone Medicine	☐	☐	Allergies (Pollen/Dust)	☐	☐
Anemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Artificial Joint*	☐	☐	Hives or Rash	☐	☐
Excessive bleeding	☐	☐	Ulcers	☐	☐	Venereal Disease	☐	☐	Birth Control	☐	☐
Sickle Cell Disease	☐	☐	Recent Weight Loss	☐	☐	AIDS	☐	☐		☐	☐

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	REVEIWED BY
_____	_____	None ☐ _____	_____	Dr. Narkhede
_____	_____	None ☐ _____	_____	Dr. Narkhede
_____	_____	None ☐ _____	_____	Dr. Narkhede

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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}

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

_____

_____

_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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

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 heath 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.

REVOCATION 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: _____