Welcome To Our Practice

Thank you for choosing us as your dental care provider. We are committed to providing you with the best possible care and your treatment success. A clear understanding of our policies is important for our professional relationship.

On your first visit, we will perform necessary x-rays, Periodontal (gum) exam, blood pressure check, hygiene, and intraoral images of your teeth. Based on our findings, we will recommend a treatment plan. If mutual schedules allow, we will begin recommended treatment, with your permission. Otherwise, a more convenient time will be scheduled.

General Office Policies:

We believe your time is as valuable as ours. To assist us in our efforts to stay on time, we ask that you please arrive on time for your appointment. **If you are more than 15 minutes late it may be necessary to reschedule your appointment for a later time or day.**

We understand that unplanned circumstances can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 hours in advance. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients. **There may be a fee of $50.00 assessed if we do not receive 48 business hour call to cancel.**

You may be asked if you have any changes in address, phone number, or medical history on subsequent visits. Parents or guardians must accompany minors for all dental visits. Treatment will be denied for any unaccompanied minors.

Payment and Insurance policies:

Returned checks- are subject to $30.00 service fee and will also be turned over to collections department if not taken care of within 7 business days.

Patient's Records: $25:00 processing fee is applicable for all patient's records request. All request is going to be processed in five business days.

Personal Injury Cases- This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

Interest/ Finance Charge – An interest 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. A payment plan agreement is interest free for the payment period; however, in the event of payments being past due, a monthly finance charge of $25 will be added.

Insurance Patients: (*Please read carefully and initial*)

We must emphasize that as a Dental Care Provider, our relationship is with you, our patient, not with your insurance company. You will be responsible for paying your annual deductible, copayment charges, patient portion and any non- covered or cosmetic services at the time of service. As a courtesy to our patients, our office will file insurance claims on your behalf to avoid delays or denials to your claim. Please make sure our office has your correct billing information on file. It is your responsibility to notify us as soon as possible of any insurance changes so we can make the appropriate adjustments and optimize your benefits. ***Your insurance policy is a contract between you, the insurance company and your employer.*** **If your insurance company does not pay your claim within 60 days, we will transfer liability of the claim to you. We cannot guarantee payments of insurance claims; we can only *ESTIMATE* your portion**. It is very important that you understand the provisions of your policy. If any alternate benefit provisions exist on your plan, we recommend that you familiarize yourself with your plan, as our office will automatically provide cosmetically inclined restorations, unless otherwise indicated by you the patient.

Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
Initials_____

We thank you for understanding our office policies. This has become necessary in order to continue to accept insurance plans without having patients pay the full balance up front and then wait themselves for reimbursement from their insurance company. Our goal is to make your visit with us as pleasant and professional as possible. If you have any questions, please feel free to ask our staff for assistance. Thank you for choosing us for your dental care.

Complaints:

If you are not satisfied with our service or believe your privacy rights have been violated, please tell us. Sai Dental wants to hear your suggestions so we can continually improve our services. If you wish to file a complaint, you may do so by contacting our office at (972) 793-0653 and we will direct you to how to fill out a complaint. You may also submit a written complaint to the U.S. Department of Health and Human Services. Sai Dental will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Acknowledgement:

I understand that the estimated fees listed on the treatment plan for dental care, can only be extended for a period of 90 days from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 here under.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Patient's name (please print)	**Signature of patient**	Date

Signature of Guarantor / Responsible Party	Relationship to Patient	Date

Your First visit with us…

We will perform a complete exam and take the necessary x-rays, Periodontal (gum) exam, blood pressure check, hygiene, and intraoral images of your teeth. Based on our findings, we will recommend a treatment plan for you including what needs to be done.

If mutual schedules allowed, we can start some of your treatments with your permission, alternatively you can make an appointment to return to start your treatment.

Before we can get started though, we need you to look over and fill out the following forms:

New Patient Forms

Medical and Dental information Forms

HIPPA Compliance Form

Financial and Dental Insurance Policy

You can rest assured that all of your information will remain confidential.

Please take a moment to read the following consent.

The undersigned herby authorizes Dr. Ami Bhatt/ Sai dental assistant to take radiographs, study models, or any other diagnostic aids deemed appropriate by Dr. Bhatt to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with this patient, and further authorize and consent that Dr. Bhatt to choose and employ such assistance as she deems fit. I understand that responsibility for payment for dental services provided in this office for me or my dependents are mine, and are due and payable at the time services are rendered, unless previous arrangements have been made.

_____

Patient's name (please print) Signature of patient or legal guardian Date

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Email Address: _____
Please include your email address; it will also be used to confirm all dental appointments. Thank you.

Patient Information

Patient Name _____ Date: _____
Last, First, MI (Preferred Name)

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Singled ☐ Child

Social Security #: _____ Birth Date: _____

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

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F

Address: _____ Driver License# _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Redux or Fen-Phen_____
☐ Bisphosphonates
OTHER:_____

Medications currently taking:

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Do you prefer Nitrous Oxide (laughing gas) during your dental appointment? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Emergency Contact (Name & Number)

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Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____ Driver License# _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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 cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such 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.

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

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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. If I am unable to keep my scheduled appointment, _____will be notified 24 hours in advance, if missed, a fee of $25.00 may be assessed.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

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Dental History

PATIENT NAME_____Date of Birth_____

Reason for this visit_____

When was your last dental visit_____ What was done then_____

How often did you visit the dentist before then_____ General Dentist_____

Prior (if less than 2yrs)_____Have you had a complete series of x-rays taken (when/where)_____

How often do you brush your teeth _____How often do you floss_____

Type of toothbrush used_____ Is your drinking water fluoridated_____

CIRCLE ONE:

Do your gums bleed while brushing/Flossing	**Yes / NO**	Do you bite your Lips or cheeks frequently	**YES / NO**
Are your teeth sensitive to hot or cold	**YES / NO**	Have you noticed any loosening of your teeth	**YES / NO**
Are your teeth sensitive to sweet or sour foods	**YES / NO**	Does food get caught between your teeth	**YES / NO**
Have you ever had periodontal treatment	**YES / NO**	Ever worn a bite plate or other appliance	**YES / NO**
Do you have any sores or lumps in or near your mouth	**YES / NO**	Have you ever had any difficult with extractions	**YES / NO**

Have you ever experienced any of the following problems in your jaw

Clicking	**YES / NO**	Do you wear dentures or partials	**YES / NO**
Pain (joint, ear, side or face)	**YES / NO**	If YES, Date of Placement_____	
Difficulty in opening or closing	**YES / NO**	Do you have frequent headaches	**YES / NO**
Difficulty chewing	**YES / NO**	Do you clench or grind your teeth	**YES / NO**

Have you ever received oral hygiene instruction regarding the care of your teeth and gums? **YES / NO** If you could change anything about your Smile, what would you change? _____

AUTHORIZATION AND RELEASE CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUSTIONS HAVE BEEN ACCURATELY ANSWERED: I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH, I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITION ERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST INSURANCE BENEFITS OTHERWISE PAYABLE TOME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES; I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

PATIENT/GUARDIAN SIGNATURE_____ DATE_____

DOCTOR'S SIGNATURE _____DATE_____

RELEASE OF MEDICAL RECORDS CONSENT

In order to ensure proper follow-up and continuity of care, I _____
Patient's name (please print)

agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

_____ _____
Signature of patient or legal guardian Date

I further authorize the release of my records, x-ray reports, laboratory reports from this office as well as reports from any other physician's offices to other health care professionals or to my place of employment if requested.

_____ _____
Signature of patient or legal guardian Date

(Please circle one)

This office has my permission to contact me by telephone , e-mail, text message or leave message on voice mail to remind me of appointments scheduled.

YES NO

This office has my permission to send me recall reminders through the mail, telephone ,e-mail or text message for my necessary appointments

YES NO

Acknowledgement Receipt Notice of "HIPPA" Privacy Practices

** You May Refuse to Sign This Acknowledgement**

This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of the Sai Dental with respect to health information created for services generated at Sai Dental.

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

_____ _____

Signature of patient or legal guardian 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

____ Communication barriers prohibited obtaining the acknowledgement

____An emergency situation prevented us from obtaining acknowledgement - Other (please specify)

_____
_____
_____
_____