



**DR. DUDHAT & ASSOCIATES**

*We make you smile*

abingtondmd@yahoo.com

www.abingtondmd.com

215-881-8551

**Abington Dental Excellence**

**1130 Old York Road**

**Abington, PA 19001**

**PATIENT INFORMATION**

Patient's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address: (Street/Apt.) \_\_\_\_\_ (City) \_\_\_\_\_ (St) \_\_\_\_\_ (Zip) \_\_\_\_\_

SS#: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: Minor( ) Single ( ) Married (

Phone No: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Separated ( ) Divorced ( ) Widowed (

Additional Phone/Cell No: \_\_\_\_\_ Student? \_\_\_\_\_ Full-time ( ) Part-time ( )

Spouse/Parent's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Are any of your family members our patients? (Yes/No) \_\_\_\_\_ If Yes, Who? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Previous Dentist's Name and Phone No.: \_\_\_\_\_

Last Dental Visit (Date): \_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

Name of Insurance Co.: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Date of birth \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ SS No./ID No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Name of Insurance Co.: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Date of birth \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ SS No./ID No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

**HEALTH HISTORY**

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Physician's Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

YES    NO

\_\_\_\_\_ Are you having any pain or discomfort at this time?

\_\_\_\_\_ Have you ever had a full mouth x-rays taken of your teeth? If yes, when? \_\_\_\_\_

\_\_\_\_\_ Have you ever had treatments for your gums?

\_\_\_\_\_ Do your gums hurt or bleed when you brush?

\_\_\_\_\_ Do your teeth hurt when you chew?

\_\_\_\_\_ Have you ever been aware of a bad odor or taste in your mouth?

\_\_\_\_\_ Are your teeth sensitive to hot, cold or sweet?

\_\_\_\_\_ Do you clench or grind your teeth during day or night?

\_\_\_\_\_ Do you ever wake up from sleep due to shortness of breath?

\_\_\_\_\_ Have you ever had orthodontic treatment or worn braces?

\_\_\_\_\_ Are you on a special diet?

\_\_\_\_\_ Do you use a tobacco products? What and how much \_\_\_\_\_

\_\_\_\_\_ Do you use controlled substances? How much \_\_\_\_\_ How often \_\_\_\_\_

\_\_\_\_\_ Have you been a patient in the hospital during the past two years? For what \_\_\_\_\_

\_\_\_\_\_ Have you been under the care of a medical doctor in past years? For what \_\_\_\_\_

**HEALTH HISTORY (CONT'D)**

**FOR WOMEN ONLY**

- \_\_\_\_\_ Are you now or think you may be pregnant?
- \_\_\_\_\_ Are you nursing?
- \_\_\_\_\_ Are you presently taking birth control pills?

THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

Are you **Allergic or have your reacted adversely** to any of the following medications?

- |               |                        |                      |                    |
|---------------|------------------------|----------------------|--------------------|
| _____ Aspirin | _____ Erythromycin     | _____ Percodan       | _____ Sulfa        |
| _____ Codeine | _____ Local Anesthetic | _____ Penicillin     | _____ Tetracycline |
| _____ Darvon  | _____ Scopolamine      | _____ Valium         |                    |
| _____ Demerol | _____ Nitrous Oxide    | _____ Sleeping Pills |                    |

Other, if yes, please explain: \_\_\_\_\_

Check any of the following you have had or have at present:

- |                                  |                                |                                       |
|----------------------------------|--------------------------------|---------------------------------------|
| _____ AIDS (HIV)                 | _____ Diabetes                 | _____ Mitral Valve Prolapse (MVP)     |
| _____ Arthritis                  | _____ Emphysema                | _____ Nervousness/Irregular Heartbeat |
| _____ Asthma                     | _____ Epilepsy or Seizures     | _____ Pacemaker                       |
| _____ Angina Pectoris            | _____ Fainting or Dizzy Spells | _____ Pain in Jaw Joints              |
| _____ Artificial Heart Valve     | _____ Genital Herpes           | _____ Psychiatric Care                |
| _____ Anemia                     | _____ Glaucoma                 | _____ Rheumatic Fever                 |
| _____ Artificial Joints          | _____ Heart Disease or Attack  | _____ Rheumatism                      |
| _____ Allergies or Hives         | _____ High Blood Pressure      | _____ Radiation Treatment             |
| _____ Bruise Easily              | _____ Heart Murmur             | _____ Renal Dialysis                  |
| _____ Blood Transfusion          | _____ Heart Pace Maker         | _____ Sinus Trouble                   |
| _____ Cancer                     | _____ Hay Fever                | _____ Sickle Cell Disease             |
| _____ Congenital Heart Disorder  | _____ Hepatitis A              | _____ Stroke / Swelling of limbs      |
| _____ Cold Sores/ Fever Blisters | _____ Hepatitis B or C         | _____ Scarlet Fever                   |
| _____ Cough/Frequent Cough       | _____ Hemophilia               | _____ Thyroid Disease                 |
| _____ Cortisone Medicine         | _____ Herpes                   | _____ Tuberculosis (TB)               |
| _____ Chemotherapy               | _____ Kidney Problems          | _____ Tumors or Growths               |
| _____ Drug Addiction             | _____ Liver Disease            | _____ Ulcers                          |
| _____ Chest pains                | _____ Leukemia                 | _____ Venereal Disease                |
| _____ Parathyroid Disease        | _____ Lung Disease             | _____ Yellow Jaundice                 |

List any other condition not listed above: \_\_\_\_\_

Dr's. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dr's. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dr's. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dr's. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions accurately. 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 examinations rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill of services. I agree to be responsible for payments for all services rendered on my behalf or my dependents. The dentist agrees to consider the amount paid as a participating provider from the participating insurance companies.

X \_\_\_\_\_ Date: \_\_\_\_\_

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

**DENTAL OFFICE INFORMED CONSENT**

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may, with your agreement, perform. We want to involve you in all decisions concerning invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is a risk associated with dental procedures, and all your questions have been answered.

Dental treatment and procedures are not to be taken for granted as being routine or without risk for complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are potentially many variables, some predictable and others are not. Complication rates in dentistry are low but do exist. Even a minor procedure like "filling" can lead to major complications that cannot be foreseen. For example, "**Novacaine**" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. These are fairly granted uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These kinds of complaints can be transient or may persist requiring further treatments. The above examples are some samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems.

I have read, understand and consent to dental treatments.                      INITIALS: \_\_\_\_\_ DATE: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT**

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

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

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_

**PATIENTS WITHOUT INSURANCE COVERAGE**

Patients without insurance coverage are required to pay for services as rendered. We accept cash, Visa, MasterCard, American Express and Discover or Debit/ATM cards. We offer an In-House Membership Plan. We offer 3% courtesy on the prepayment of *Patient-Doctor discussed treatment* plans. We offer up to 12 months **INTEREST-FREE** financing payment plans.

**OFFICE POLICY**

When you make an appointment we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We reserve the right to charge for any appointment(s) broken without a 48 hours notice. **The charge will be \$35.00. Checks returned from the bank are subject to a \$40.00 service fee.**

Accounts delinquent more than 30 days from the date of billing are subject to a 1.5% per month (12% annually) finance charge. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

We welcome you to our office and want to provide you with the best dental care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

**I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED CONSENT AND FINANCIAL POLICIES.**

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

**OUR FINANCIAL POLICY**

Thank you for choosing us as your dental care provider. We are committed to your dental treatment being successful. We agree in writing with every patient to sign our financial policy, as we have found with our past experience that this policy makes our mutual experience easier and without confusion. This policy is to ensure that all of our patients receive a highest level of quality dental care in a friendly and healthy environment while understanding their financial responsibilities. This policy as well as other health and insurance forms provided must be read, agreed to, and signed prior to any dental treatment.

**Cash Patients**

Patients with no insurance are expected to pay in cash, check or credit card the day the service is rendered, unless specific arrangements are made in advance OR getting our **CUSTOMIZED MEMBERSHIP PLAN**.

**Insurance Patients**

For those patients covered by insurance, we may accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Very few insurance policies cover 100% of the cost of your treatment. In this day and age many cover 50% or less on many services and actually cover nothing on others. Due to this, and the frequent delays in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will estimate as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. Some patients request that we send in a pre-determination to their insurance carriers. We state what treatment you need, and they tell us what they will cover on that treatment plan. Many patients prefer to get services started immediately, and some treatments should be started immediately. In these cases we will ask you to pay for your services in full as they are done (For an example: RCT, Implant placement), and when the insurance company pays their portion we will reimburse you for what they pay. **We will help you in dealing with the insurance company, but ultimately the responsibility of payment and insurance problems lies with you.** If we do accept assignment of benefits from the insurance company, if the insurance company hasn't paid after 30 days, the full balance is expected from you personally.

The above policies apply equally to parents and guardians of minors being treated, and minors cannot be treated without a parent or guardian authorizing treatment and agreeing to financial responsibility. Thank you for reading and understanding our financial policies. If you have any questions or concerns; please feel free to ask them at any time. We wish to be of assistance in any way we can.

Sincerely,

Dr. \_\_\_\_\_

**I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED FINANCIAL POLICIES.**

\_\_\_\_\_  
Signature of responsible party

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

\_\_\_\_\_  
Please print your name

**FINANCIAL ARRANGMENT VIA AUTHORIZATION TO CHARGE CREDIT/DEBIT CARD:**

I, \_\_\_\_\_, give permission for Dr. \_\_\_\_\_ to charge the remaining balance of \$ \_\_\_\_\_ not to exceed, \$ \_\_\_\_\_ after insurance payment. I understand that I am responsible for all charges regardless of the outcome of my insurance claim. Card # \_\_\_\_\_ Exp: \_\_\_\_\_

Amount to be charged: \$ \_\_\_\_\_  
Insurance payment received: \$ \_\_\_\_\_  
Balance charged to credit card: \$ \_\_\_\_\_

**❖ WE OFFER DENTAL WARRANTY & STAND BEHIND ON OUR DENTAL TREATMENT. PLS. ASK DOCTORS FOR DETAILS.**