Date: _____Patient Name: _____ _____
(First) (Last) MI (Preferred/Nick Name)

Single____Married____Widowed____Divorced____ Gender: M F Preferred Contact Method: _____

Address: _____ City: _____

State: _____ Zip: _____ Social Security Number: _____ Birth date: _____

Home Phone: _____ Business Phone: _____Cell Phone: _____

Employer: _____ Occupation: _____

Business Address: _____

Email Address: _____ Person Responsible for Account:_____

Do you have dental insurance? Y N Name of Company :_____ Insurance ID _____

Do you have health insurance? Y N Name of Company :_____ Insurance ID_____

How did you hear about Dr. Kumar/Essel Dental?_____

Whom may we thank for this referral? _____

My Dental Health: please make one choice.

1. My mouth is….. A.) very comfortable
B.) comfortable
C.) uncomfortable

2. I…. A.) think the appearance of my mouth is excellent
B.) think the appearance of my mouth is just okay
C.) do not like the appearance of my mouth

3. I… A.) will do anything to keep my natural teeth
B.) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them
C.) don't care whether I keep my teeth or not

4. I… A.) have set goals for my oral health in the past
B.) have NOT set goals for my oral health in the past but would like to
C.) do NOT want to set goals for my oral health

5. I… A.) have always done the best that was recommended for my dental health
B.) have not done what dentists have recommended for my mouth

6. I have... A.) put dentistry for myself and my family high on my priority list
B.) put dentistry for myself and my family low on my priority list

7. I think my dental health is……. A.) excellent
B.) good
C.) poor

8. I want a mouth with… A.) excellent health
B.) good health
C.) poor health

9. What are your main concerns?

General Consent to Dental Treatment

_____
Initial Here
I understand the purpose of this general consent is to raise my awareness of risks that are common-place in many dental procedures. I understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurances as to the outcome or results of treatment or surgery. I have the right to ask my dentist for more information if I have any concerns about my procedures and the possible side effects or complications, and I promise to use that right to its fullest extent if for any reason I feel I am not fully informed about my procedure, the risks of the procedures, and my alternatives to the procedure, including no treatment.

My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care. I understand that some after-treatment effects and complications tend to occur with regularity.

Photography Release

_____
Initial Here
I do hereby authorize Dr. Kumar and/or his assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth. These photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, marketing and professional publications (journals, magazines), Websites and promotional Materials. If the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

HIPPA Consent Signature Form

_____
Initial Here
I hereby acknowledge that I have received a copy of the Notice of Privacy Practice of My Enfield Dentist, LLC dba Essel dental for review. I have been given the opportunity to ask any questions that I have regarding this Notice.

Medical Dental Benefits Submission Signature Form

_____
Initial here
I hereby authorize the office of Essel Dental to submit, on my behalf, claims for coverage to the company that administrates my medical and dental benefits policies. I understand that some benefits may be paid directly to Essel Dental and that some benefits may be paid directly to me. I agree to uphold financial agreements between myself and Essel Dental regardless of the fashion in which said claims are reimbursed.

Signature _____ Date _____

Patient Name_____ Date of Birth: _____
(First) (Last)

ESSEL DENTAL: PATIENT MEDICAL / DENTAL HISTORY

Name: _____ **Date Of Birth:** _____
(First) (Last)

Sex: M ☐ F ☐
Are you taking Birth Control Pills? Y☐ N☐ Do you smoke or use tobacco? Y☐ N☐
Are you pregnant? Y☐ N☐ If so, # of weeks Do you use Recreational Drugs? Y☐ N☐
Aree you nursing? Y☐ N☐ **Height:** **Weight:**

Y	N	**Conditions:**
☐	☐	Abnormal bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer-Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	**Conditions:**
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	**Conditions:**
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	**Allergies**:
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other:

Do you have any of the following diseases of problems?

Active Tuberculosis, Persistent cough more than 3-week duration, cough that produces Blood or been exposed to anyone with Tuberculosis: Y N (If "Y", Please stop and speak with Receptionist).

Dental Information:	Y	N		Y	N
Do your gums bleed when brush/floss?.....	☐	☐	Do you have earaches/neck pains?.....	☐	☐
Sensitive to cold/hot/sweet/pressure? ……	☐	☐	Clicking/popping/discomfort of jaw?	☐	☐
Does Food/floss catch b/w teeth?.....	☐	☐	Do you brux/grind your teeth?.....	☐	☐
Is your mouth Dry?.....	☐	☐	Any sores/ulcers in mouth?.....	☐	☐
Have you had Periodontal/Gum Treatment?	☐	☐	Do you wear Dentures/Partials?.....	☐	☐

_____ _____
PATIENT SIGNATURE DATE

ESSEL DENTAL: PATIENT MEDICAL / DENTAL HISTORY

Do you have any of the following medical conditions?	Y	N
Artificial Total Joint Replacement (Hip, Knee, Elbow, Finger etc.) ……	☐	☐
Artificial Heart Valve ……...	☐	☐
Previous infective Endocarditis ……	☐	☐
Damaged valve in Transplanted Heart…….....	☐	☐
Congenital Heart Disease:		
Unrepaired, cyanotic CHD …….....	☐	☐
Repaired (Completely) within last 6 months ……	☐	☐
Repaired CHD with residual Defects …….....	☐	☐
Were you treated to presently scheduled to begin treatment with intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia, Paget's Disease, Multiple Myeloma or cancer?	☐	☐
Are you taking medications like Aldronate (Fosamax) or Risedronate (Actonel) for Osteoporosis or Paget's Disease? ……..	☐	☐

Your Physician's Name: Phone: Last Physical Date:
Are you being treated by your physician currently for any condition?
Are you taking any medications currently? Please list all Meds here:

Did any physician or previous dentist asked you to take Antibiotic prior to Dental Procedures?

Do you have any disease, condition or problem not listed above?

Date of your Last Dental Visit and what was done:
Date of your Last Dental X-rays:
Date of your Last Dental Hygiene Appointment:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____

PATIENT SIGNATURE DATE

Acknowledgement of Receipt of HIPAA Policies and Procedures

This sample form illustrates how a dental practice might obtain acknowledgement of receipt from each workforce member that he or she has received a copy (in paper or electronic format) of the practice's privacy, security and breach notification policies and procedures.

Essel Dental
_____
{Name of Practice}

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Patient's Name:_____ _____
(First) (Last) (Date of Birth)

Signature:_____

Date:_____

We are establishing a relationship, you as our patient and us as your dental health care team. To eliminate or minimize misunderstandings here are our clear expectations of how this new relationship shall be established. This agreement is based on our mutual respect concerning:

1- Time:

We as an office will value your time by scheduling appointments in as convenient a manner as possible for your circumstances and by promptly seating you for and providing your treatment.

You as a patient will value our time by providing advanced notice of your need to reschedule or cancel an appointment, by minimizing the number of times an appointment needs to be changed and by arriving promptly for your reserved time with us.

Persons arriving ten or more minutes late for a reserved appointment will be rescheduled. A person that reschedules, with less than 24 hours notice, two consecutive appointments or three appointments in a 6-month period will be seen only on a short notice status. This means that we will no longer reserve appointment time for you in advance. You can contact us for an appointment time and if one is available that day you may be scheduled into that reserved time.

Any time that a person does not arrive for their reserved appointment time without notifying our office team a serious breach of trust has occurred. If this becomes a pattern of behavior and a second appointment is missed in a similar fashion you will be seen on an emergency basis for 30 days from the date on the written notification of dismissal from the practice.

Office reserves the right to charge for time which was reserved for your appointment. This office policy is to charge at least $50 or up to half of production loss suffered for Broken Appointments (Appointment with you not showing or not giving us at least 48-hour advance notice of cancellation). Since we have an obligation to schedule our staff according to your appointment, it is equally your obligation to inform us well in advance if you cannot keep your appointment.

2-Health/Treatment:

We as a group will dedicate ourselves to helping you achieve optimal health while respecting all of the many influences that impact you and your ability to achieve or maintain the health that you and I, as partners, define for you. Additionally, all the treatment that we provide to you will be of the finest quality we are capable of.

You as a patient will also dedicate yourself to reaching and maintaining dental and overall physical health as you and I have defined it for you. You will accomplish this by completing treatment that you have agreed to and through compliance to the hygiene habits taught by Dr. Kumar and the team.

3- Money:

All of us can agree that money is a vital part of our daily lives and that a hard earned dollar is not something to be parted with foolishly. Our agreement with you in regards to money is simple.

We will provide for you with our very best skill, judgment and care at a fair measure.

You in turn will meet your obligation by making timely payment for the services provided.

While we will have a relationship with the insurance company that provides your dental benefit, the relationship that we really value is the one that we have with you; as such we want to be clear about our expectations.

Payment in full for services provided with in a reasonable time frame. As a courtesy to you we will verify your dental benefits and accept payment from the company that provides you with this benefit. It is your responsibility to settle all accounts with us for services provided, with in 60 days of said provision of service, regardless of the actions taken by your dental benefits company.

Any accounts due after 60 days may be sent to a collection agency. The additional collection agency fees which may be added to your account are minimum $300 and can go up to 50% of due on your account balance. Once we hand over your account to collection agency, we will not be able to make payment arrangements directly with you and you will be required to make all account inquires with collection agency only.

If you have to stop treatment in the middle, you will be responsible time spent up to that point along with any lab cost incurred by our office even if we are unable to deliver you the dental work performed.

Any payments that are your responsibility above and beyond the terms of your dental benefit plan will be expected at the time of service, this includes unmet deductible and co-payment amounts.

The terms of your benefit plan are important and can impact how you approach your care. It is in **your best interest to understand the policy that dictates payments from your benefits company**. Please keep in mind that your health is my top priority, your dental benefits company can make no such statement. I encourage you to be familiar with your plan, without letting your benefits dictate how we set your treatment goals. In order to assist you in obtaining affordable care we have a number of ways to structure the collection of our fees. The next page of this document outlines the ways we can help you receive the care that is most appropriate for you.

_____ _____

Patient Name Date

_____

Signature of Responsible Party for this Account

Name of Person Signing this document (If different from Patient):

Relationship to Patient (If different from Patient):