(PLEASE PRINT)

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

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

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Dental Registration and History

Health History

Physician's Name _____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with			Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
extractions or surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head		
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name_____

Phone (_____) _____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

ERIC S. CHOUDHURY, D.M.D., M.D.S., P.A.
PERIODONTICS • DENTAL IMPLANTS • COSMETICS

Smile Evaluation

Do you like the way your teeth look? **YES** **NO**

Are you happy with the color of your teeth? **YES** **NO**

Would you like your teeth to be whiter? **YES** **NO**

Would you like your teeth to be straighter? **YES** **NO**

Did you know you could straighten you teeth without braces? **YES** **NO**

Do you know about Invisalign, the invisible way to straighten you teeth? **YES** **NO**

Do you have space between your teeth that you would like closed? **YES** **NO**

Would you like your teeth longer?
If so, Upper _____ Lower _____ Both _____

Do you like the shape of your teeth? **YES** **NO**
Explain: _____

Do you have missing teeth that you would like to replace? **YES** **NO**
Explain: _____

Do you have old silver fillings that you would like to replace with Tooth- colored fillings?
YES **NO**
Explain: _____

If you could change anything about your smile, what would you change?
Explain: _____

9700 RICHMOND AVE. SUITE 149
HOUSTON, TX 77042

PHONE (713) 771-9308
FAX (713) 981-4744

www.WeImplantSmiles.com

Eric S. Choudhury, DMD, MDS, PA

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I authorize payment of dental benefits to Dr. Choudhury for services rendered, and further understand that if at the end of 60 (sixty) days from the date of filing the claim my insurance company does not respond with payment to my account, I am responsible for the full amount of the charges.

I acknowledge and understand that I am responsible for all the charges and for all the services rendered to me or any member of my family.

SIGNED_____DATE_____

Eric S. Choudhury, DMD, MDS, PA
9700 Richmond Ave. Suite 149 Houston, TX 77042
713-771-9308 Office 713-981-4744 Fax

Insurance & Financial Policy

Our goal in discussing financial arrangements relative to your dental needs includes:

- to inform you of treatment alternatives
- their respective advantages and disadvantages
- the consequences and/or risks of limited delayed treatment and/or non-treatment

> Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.

> Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a predetermined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which your insurance agreement allows. However, this should not have control over what is in your best interest as far as treatment is concerned.

> For your convenience, we will estimate the portion of the fee that your insurance company will not cover. This is just an estimate. After your insurance benefits have been paid, you are responsible for any unpaid balance. We will ask you to bring with you at the time of treatment the estimated uncovered portion of the total fee.

> It is not possible to know exactly what your insurance coverage will be prior to treatment, as treatment sometimes changes. We can predetermine your benefits with your insurance company; however, this delays treatment 4-6 weeks or longer, waiting for the insurance company to respond, which may not be in the best interest of your oral health.

> A finance charge of 1-1 1/2% will be added to your bill if payment has not been received within 60 days. This will allow adequate time for your to ensure that your insurance benefits have been paid to your satisfaction.

> Should collections become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and courts costs.

> Our policy, and most dental plans, require a percentage fee, (co-payment) to be paid at the time of your treatment. Full payment is required at the time of service if you are not covered by a dental plan.

Payment Options:

- Cash
- Check
- Visa, Mastercard
- CareCredit

I authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay an uncovered balance. I hereby authorize release of information for insurance purposes.

_____ _____

Signature of Patient (or Guardian) Date

ADAIDM/12-08

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Dental Insurance

- Dental insurance benefits do not work in the same way as medical insurance. There is almost always a co-payment due from the patient for almost every procedure.
- There are “deductible” in almost all plans. At one time these deductibles were never taken out of preventive treatment (“exams, x-rays”). Recently many carriers have begun to take deductibles out of preventive treatment.
- Irrespective of any dental insurance benefits that might exist, the patient is always legally responsible for the entire cost of dental treatment.
- The extent of dental coverage is solely dependent on the dental insurance plan purchased by the employer. The higher the premium the employer pays, the greater the dental insurance benefits.
- Even if there is a written predetermination of benefits returned from the insurance carrier, it is possible that after treatment is provided, there are no insurance benefits payable.
- We (the dental office) have absolutely no power or leverage to deal with the insurance carrier. Only the employee or the contract purchasers has that power. Any complaints about benefits, payment, or coverage should be directed to Human Resources or the company owner.
- The letters “UCR” on insurance vouchers stand for Usual, Customary, and Reasonable. The dollar amount you see as UCR has no basis in reality. It is an arbitrary amount determined solely by the plan selected and insurance premium paid by the employee. There is no relationship to the actual dental office fee. The better the plan (i.e., the more premium paid), the higher the UCR will be.
- A single insurance carrier may have a dozen different UCR fees for the same procedure, same office, and same dentist.
- There is no universal coverage and payment schedule established. Just because an insurance code describing a dental service exists, it does not guarantee that it will be a paid benefit under your policy. There are many dental procedures that are necessary, and many of them are preventive, but are not covered benefits.
- Your dental benefits almost always have a yearly maximum contribution level. This amount is the most your insurance carrier is contractually obligated to pay during a defined year (calendar or otherwise). When this amount is reached, there will be no further dental benefits payable until the next benefit year. If you have already begun some additional dental treatment prior to the maximum being reached, the insurance carrier has no payment obligation beyond that of the annual maximum.
- Insurance benefits cannot be saved and carried over into the next year.

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HIPAA Act

How the Health Insurance Portability and Accountability Act (HIPAA) Will Affect Your Next Dental Visit

The US Department of Health and Human Services has recently issued national health information privacy standards. The Health Insurance Portability and Accountability Act, a federally mandated law known as HIPAA, is designed to:

- provide protection for the privacy ofcertain identifiable healflt data (callel protected health infornatio\ [PHI]),
- ensure health insurance coverage when changing employers, and
- provide standards for facilitating electronic transfers of health care-related information.

While the privacy of your personal PHI will remain confidential, certain aspects of this law will permit disclosures of PHI to facilitate public health activities. The following charts review the types of health dated disclosure allowed under HIPAA.

PHI can be disclosed with your authorization in the following categories.

You may request a limitation or restriction on the disclosure of this information. You have the right to:

- request a restriction or limit of any of the above disclosures used for treatment, payment, or office operations.
- inspect and copy information that may be used to make decisions about your care.
- request an amendment of this information if you feel it is incorrect or incomplete.
- an accounting of disclosures we have made that were not related to treatment, payment, or operations of this office.

These requests must be submitted in writing to the office manager and you will be informed of the specifics that are required.

Treatment - PHI will be used to provide appropriate treatment either by this office or other healthcare providers, diagnostic or fabrication laboratories.

Payment - PHI will be used to facilitate payment for treatment rendered. Your health plan requires this information in order to bill, collect payments, or obtain approval prior to treatment.

Healthcare Operations - In order to ensure all patients receive timely and quality care, PHI will be used to facilitate the daily operations of our practice. These include, but are not limited to:

- clinical/research studies to improve our practice
- appointment reminders by phone calls or mailings
- sign-in sheets used to notify us of your arrival
- posted appointment schedules
- information regarding your treatment options or related benefits and services
- communications with family or friends that are involved in your care or payment for your care

PHI can be disclosed without your authorization in the following categories.

As Required by Law	**Judicial & Administrative Proceedings**	**Oversight** PHI can be disclosed to a health oversight agency as authorized by law for audits, investigations, inspections, and licensure.
Public Health	**Lawsuits & Disputes**	**Workers' Compensation** PHI may be released to workers' compensation or similar programs that provide benefits for work-related injuries or illness.
Public Health Risks	**Law Enforcement**	**Military & Veterans**
Health Research PHI disclosuresa rep ermined when required by federal, state, tribal. or local laws.	**Coroners & Medical Examiners** Release of PHI to officials will occur: in response to a court order, subpoena, discovery request or summons; to identify a suspected fugitive, witness, or missing person; about a victim of crime if unable to obtain permission from the person; to identify a deceased person, determine cause of death, about a death that is believed to be the result of criminal conduct; criminal conduct occurring at the practice; in emergency situations.	**National Security and Intelligence Activities**
Abuse, Neglect, or Domestic Violence PHI can be disclosedto preventa threat to your health and safety or the health and safetv of others.	**Cadaver Organ, Eye, or Tissue Donations** PHI disclosure can be made to organ banks as necessary to facilitate organ or tissue donation and transplantation.	**Protective Services for the President & Others** PHI may be released as authorized by law when requested by military command authorities, federal officials for national security, and protection of the president and other heads of state.

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