Tejal A. Kakade, D.M.D., P.C.
Personalized Dentistry

Patient Information & Insurance Form

Date ______________ Patient Name ____________________________________ Name you wish to be called _______________
Physical Address ____ Home Phone ___________________________
City ______________________ State ___________ Zip Code ________________ Cell Phone _____________________________
Mailing Address ____ Email _________________________________
City ______________________ State ___________ Zip Code ________________
Sex: Male Female Age ___________ Birthdate __________________ Single-Married-Widowed-Separate-Divorced
Patient SS# ________________________________ Patient DL# _________________________
How do you wish for us to contact you? Home Phone Cell Phone Email
Occupation ___________________________ Employer ___________________________ Employer Phone ________________
Spouse Name __________________________________ Birthdate ___________________ SS# _____________________________
Spouse's Occupation _____________________________ Spouse's Employer ____
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Whom may we thank for referring you: Patient _________________________ Billboard Newspaper Social Media Website
Who is financially responsible for this account? ___________________________ Relationship to patient __________________
IN CASE OF EMERGENCY CONTACT (someone not living with you)
Name ___________________________________ Relationship ___________________________ Phone ______________________
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Insurance Company ____ Group # ___________________________
Subscriber's Name _______________________________________ Subscriber's Birthdate ____________________________
Subscriber's SS# _____ ______________ Relationship to Patient- Mother Father Spouse Other
Is patient covered by Secondary Insurance? Yes No
Insurance Company ____ Group# _______________________________________
Subscriber's Name _______________________________________ Subscriber's Birthdate ______________________________

ASSIGNMENT OF BENEFITS AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to the doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

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Responsible Party Signature Relationship Date
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I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.
I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.
I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

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Patient Signature or Responsible Party Signature Date

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Dental/Health History

Patient Name ____ Date of Birth ____________________________

Date of Last Dental Exam ____________ Chief Complaint ____

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First Visit Information (only new patients and their parents need to complete this section)

This is my child's first dental visit-	No	Yes
My child is worried about today's visit-	No	Yes
My child's previous visits were unsatisfactory-	No	Yes
My child had an accident, hurting the head, mouth, or teeth-	No	Yes
My child has had a toothache recently?	No	Yes

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***Teeth**

Do you have any teeth that currently hurt?	No	Yes	
Do you have any loose or broken teeth?	No	Yes	
Do you have sensitivity?	No	Yes	
Are you under the care of an orthodontist?	No	Yes	If yes, who? ____________________
Do you clench and/or grind your teeth?	No	Yes	
Are you presently taking fluoride supplements?	No	Yes	
Do you have any injuries to your mouth/gums?	No	Yes	

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***Oral Habits**

Tongue Thruster?	No	Yes
Cheek/Lip Biting?	No	Yes
Chewing pens, nails?	No	Yes
Thumb sucking/pacifier?	No	Yes

Other, please describe ____

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***Health History**

- ☐ **Chronic Earaches/Infections**
- ☐ **Epilepsy/Seizures**
- ☐ **Fainting**
- ☐ **Nervous Problems**
- ☐ **Mental Retardation**
- ☐ **Down Syndrome**
- ☐ **Autism**
- ☐ **Attention Deficit Disorder**
- ☐ **Artificial Joints**
- ☐ **Food Allergies**
- ☐ **Plant, Pollen, Grass Allergy**
- ☐ **Latex Allergy**
- ☐ **Circulation Problems**
- ☐ **Heart Surgery**
- ☐ **Artificial Heart Valve**
- ☐ **Excessive Bleeding/Hemophilia**
- ☐ **Leukemia**
- ☐ **Blood Transfusion** date ________________
- ☐ **Stomach Problems**
- ☐ **Diabetes**
- ☐ **Immunizations are up to date**
- ☐ **Chicken Pox**
- ☐ **Asthma** date of last attack ________________
- ☐ **Steroid Inhaler for Asthma**
- ☐ **Learning, behavioral, or communication problems**
- ☐ **Allergy to any drugs-please list** ________________________

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Appointment Agreement

The first step towards a beautiful, healthy smile is to schedule an appointment. Because we are a small family owned and operated dental care provider, we do not double or triple book appointments like many other doctors, in order to keep your wait time for treatment in our office to a minimum. To maintain our high standards of quality care and services, we ask that you honor our Appointment Agreement. Thank-you for choosing us and it's a privilege to serve you!

1. Please notify us, prior to seeing the dentist or hygienist of any changes to your employment, insurance coverage, primary home address, phone numbers, marital status, medical situation, or medications taken.

2. A 24 hour notice is required to cancel an appointment. If we are given less than a 24 hour notice, it is considered a broken appointment. A broken appointment is subjected to a $35 fee charged to your account. Excessive "no shows" or 3 or more cancelled appointments will be required to call on the day of the requested appointment to check for availability.

3. To prevent inconvenience to our "on time" patients, "late" patients may need to be rescheduled because we will honor our next patient with his/her reserved appointment time. Please note we do not overbook our appointments and try very hard to stay within our patients appointment times.

4. A parent or guardian must sign for children under the age of 18 years old. The parent or guardian that signs that patient in and/or makes the appointment is responsible for the minor patient's account regardless of any divorce/court orders.

Thank you for choosing us. We understand that you have a choice when selecting a dental healthcare provider for you and your family. It's an honor and a privilege to serve you.

By signing below, I've agreed that I've read, understood, and accepted the terms of the Appointment Agreement at the office of Dr. Tejal A. Kakade, DMD, PC.

Patient/Responsible Party Name (Print) ____
(First) (Middle) (Last)

Signature of patient/responsible party __________________________________Date__________

Statement of Financial Policy

Welcome to our office! We hope to make your visit a pleasant and relaxing experience. We strive for our patients to be well educated about dental health, insurance benefits, and payment options. Your review of our financial policies at this time will greatly help avoid any possible future misunderstandings and allow everyone to be more efficient.

1. Fees are expected at the time services are rendered unless other arrangements have been made. We accept Cash, VISA/Mastercard, American Express, Discover, and CareCredit.

2. We are not contracted (in-network) with your insurance company, but we will gladly file your insurance for you. You are expected to pay your estimated out of pocket portion at the time of service. We are only able to estimate your out of pocket expenses based on the information provided by you and your insurance carrier, if you need a more detailed estimate of your benefits, please contact your insurance provider.

3. Insurance coverage is determined by your contract with your insurance company. Often insurance companies will use the term “Usual and Customary”, or similar such language when denying charges for dental care. The amount an insurance company reimburses for a procedure will vary with the company, the type and quality of policy, the zip code where charges were made, and sometimes even the age or health of the patient. Our fee schedule is the same for everyone regardless.

4. We allow a reasonable time for your insurance company to pay for Dental Services. We file insurance claims electronically on the on the day of service. Claims not paid within 30 days will be automatically re-filed. We allow 60 days for your insurance to pay the claim. After 60 days you are responsible for any unpaid balance in full. All accounts are subject to finance charges (1.5%) and late fees after 60 days.

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Patient Name (print)

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Signature of Patient or Responsible Party