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**_____
****

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**_____
****

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.

_____

Responsible Party Signature Relationship Date
****

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.

_____

Patient Signature or Responsible Party Signature Date

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

Dental/Health History

Patient Name_____Date of Birth_____
Date of Last Dental Exam_____Chief Complaint_____
****

Dental Findings/History

***TMJ/Head & Neck Muscles**

Do you have muscle soreness in your head and neck? No Yes If yes, how often? _____Where?_____
Do you have clicking/popping in your jaw joint? No Yes If yes, does it hurt when it clicks/pops?_____
Do you/have you ever experienced lock jaw? No Yes If yes, how often?_____
If you experience lock jaw are you able to manipulate back in place? _____
Do you have arthritis? No Yes If yes, where?_____
Are you on medication for this? No Yes Names of meds_____
Do you clench and/or grind your teeth? No Yes Do you notice this during the day/night? _____
Do you wear a night guard? No Yes If yes, what type?
Do you have frequent headaches/migraines? No Yes If yes, what time of day?_____
Have you ever been treated for TMD? No Yes
Have you ever had Botox for TMD related issues? No Yes (Botox is an FDA approved drug to treat TMD)
****

***Sleep Assessment**

Do you snore? No Yes
Have you ever had a sleep study performed? No Yes If yes,when?_____
Were you diagnosed with sleep apnea? No Yes If yes, do you wear a CPAP?_____
If you wear a CPAP are you happy with it? No Yes
****

***Teeth**

Do you have any teeth that currently hurt? No Yes If yes, where?_____
Do you have any loose or broken teeth? No Yes If yes, where?_____
Do you collect food in your teeth? No Yes If yes, where?_____
Do you have sensitivity? No Yes If yes…cold, hot, on biting/chewing, to sweets?_____
Have you ever had orthodontic treatment? No Yes If yes, when?_____
Are you interested in Invisalign? No Yes
Do you like your smile? No Yes
If no, what would you change?_____
****

***Oral Habits**

Tongue Thruster? No Yes
Cheek/Lip Biting? No Yes
Chewing pens, nails? No Yes
Thumb Sucking? No Yes
Other, please describe_____

Patient Initials_____

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

Dental/Health History (cont)

***Oral Cavity**

Do you currently (within the past 3 months) experience any of the following conditions?

Dry Mouth/Decrease in saliva? No Yes If yes, how long?_____

Do you take anything to alleviate this? No Yes If yes, what?_____

(ex: Biotene, excessive gum chewing, over the counter or prescription medications)

Frequent Blisters/Ulcers? No Yes If yes, how often?_____

Where are the ulcers located in your mouth?_____Occur specific times of the month?_____

Do you have similar blisters or ulcers in other parts of your body? _____Where?_____

Do you have a history of any GI issues? No Yes If yes, when and diagnosis?_____

(ex:acid reflux, heartburn, IBS, UC, etc) Do you take medication for this? _____

Have you had blood work done in the last two (2) years to check for a vitamin deficiency? _____

Burning Tongue? No Yes If yes, how often?_____

Does anything relieve the symptoms?_____Which part of the tongue?_____

Bleeding or Swollen Gums? No Yes

Have you ever been told you have Periodontal Disease?_____If yes, are you under active treatment?_____

How often do you brush? _____**Bristles?** Hard Medium Soft

Difficulty Swallowing? No Yes **Difficulty getting numb**? No Yes

****

***Social History**

Do you smoke? No Yes

If yes, how often_____How long have you been a smoker?_____

Do you do smokeless tobacco? No Yes

If yes, how often_____How long have you been doing smokeless tobacco?_____

Do you drink alcohol? No Yes If yes, how many days/week? _____

****

Who is your General Physician?_____**Date of last visit?**_____

***Neurological**

Are you under psychiatric care? No Yes If yes, who is your treating doctor?_____

Do you have a history of seizures/epilepsy? No Yes If yes, date of last seizure?

History of stroke? No Yes If yes, date?_____Cause?_____

Do you suffer from anxiety? No Yes If yes, do you take medication for this?_____

Do you suffer from neuropathy? No Yes If yes, do you take medication for this?_____

***Pulmonary**

Do you have asthma? No Yes If yes, do you use an inhaler?_____

When was your last asthma attack? _____

Do you experience shortness of breath? No Yes

Patient Initials_____

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

Dental/Health History (cont)

***Cardiovascular**

Are you under the care of a cardiologist? No Yes If yes, who is your cardiologist?_____
History of a heart attack within 6 months? No Yes
Do you wear a pacemaker? No Yes
Any history of atrial fibrillation? No Yes Are you on blood thinners?_____
Do you have hypertension/high blood pressure? No Yes
If yes, what medications are you on?_____Diet restrictions?_____
What is your exercise regime? _____
Please explain any heart surgeries?_____
Do you suffer from any blood disorders? No Yes If yes, what type?_____
(ex. deficiency, anemia, lymphoma, leukemia, thrombocytopenia, etc..)
Have you been diagnosed with HIV/AIDS? No Yes If yes, do you know your CD4?_____
****

***Endocrinology**

Are you under the care of an endocrinologist? No Yes If yes, who is your endocrinologist?_____
Do you suffer from any of the following?

			Diabetes	No	Yes
Liver Disease	No	Yes	Hepatitis	No	Yes
Jaundice	No	Yes	Thyroid Disease	No	Yes
Kidney Disease	No	Yes	If yes, are you undergoing dialysis? _____		

****

***Skeletal**

Do you have osteoporosis? No Yes If yes, are you on medication for this?_____
Joint replacements or artificial joints? No Yes If yes, what type/when?_____
Who is the doctor that performed your surgery?_____
Has your physician recommended an antibiotic prior to dental treatment or cleaning?_____
****

***Cancer**

Do you or have you ever had cancer? No Yes
If yes, what type and when?_____
Have you had recent blood work checked? No Yes
Any history of head and neck radiation? No Yes If yes, when and how much?_____
****

Medications: are there any not listed? _____

***Allergies (Please circle any that apply)**

Aspirin	Local Anesthetic	Latex
Barbiturates	Penicillin	Sulfa
Codeine	Iodine	Other

If other, please list_____

***Females**

Are you pregnant	No	Yes
Nursing	No	Yes
Birth Control Pills	No	Yes

Pharmacy Name_____Phone Number_____

Patient Initials_____

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

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_____

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

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.

_____

Patient Name (print)

_____

Signature of Patient or Responsible Party

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

Patient Name:_____ Date:_____

Epworth Sleepiness Scale

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

	Chance of Dozing
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in public	_____
4. Car passenger for more than an hour without a break	_____
5. Lying down in the afternoon	_____
6. Sitting quietly after lunch (with no alcohol)	_____
7. Stopped for a few minutes in traffic	_____
Total	_____

If you snore and you have a total score of 10 or more, you should consider having a sleep study to to determine if you have sleep apnea.