Tejal A Kakade
DMD, MAGD, PC
personalized dentistry
516 Newnan Street
Carrollton, GA 30117

Patient Information & Insurance Form

Date _____ Patient Name _____Name you wish to be called _____
Address_____Cell Phone _____
City _____State _____ Zip _____Home Phone _____

How do you wish for us to contact you? Home Phone Cell Email

Social Security Number _____ Driver's License Number _____
Birthdate _____ Sex: Male Female Single-Married-Widowed-Separate-Divorced

Occupation _____Employer_____Employer Phone _____
Spouses Name _____Birthdate _____ Social Security Number _____
Spouse's Occupation _____Spouse's Employer _____

Whom may we thank for referring you: Patient _____ Newspaper Social Media Website Other
Who is financially responsible for this account? _____Relationship _____

IN CASE OF EMERGENCY CONTACT _____ Phone _____

Insurance Company _____Group # _____
Subscriber's Name _____Subscriber's Birthdate _____
Subscriber's SSN _____Relationship to Patient Father Mother Spouse Other

Is patient covered by Secondary Insurance? YES NO
Insurance Company _____Group # _____
Subscriber's Name _____Subscriber's Birthdate _____
Subscriber's SSN _____Relationship to Patient Father Mother Spouse Other

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.

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 consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____

Responsible Party Signature Relationship Date

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Dental/Health History

Patient Name _____ **Date of Birth** _____
Date of Last Dental Exam _____ **Chief Complaint** _____

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, head, mouth, or teeth injury-	NO	YES
My child has had a toothache recently-	NO	YES

Teeth

Do you have any teeth that currently hurt?	NO	YES	
Do you have 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	

Oral Habits

Tongue Thruster	NO	YES	Chewing Pens/Nails?	NO	YES
Cheek/Lip Biting?	NO	YES	Thumb Sucking/Pacifier?	NO	YES

Other, please describe _____

Health History

Please list any drug allergies: _____

Chronic Ear Infections	NO	YES	**Nervous Problems**	NO	YES
Epilepsy/Seizures	NO	YES	**Excessive Bleeding/Hemophilia**	NO	YES
Fainting	NO	YES	**Leukemia**	NO	YES
Mental Disability	NO	YES	**Blood Transfusion**	NO	YES
Down Syndrome	NO	YES	**Diabetes**	NO	YES
Autism	NO	YES	**Chicken Pox**	NO	YES
Artificial Joints	NO	YES	**Environmental Allergies**	NO	YES
Food Allergies	NO	YES	**Learning or Behavior Problems**	NO	YES
Latex Allergy	NO	YES	**Heart Problems/Surgeries**	NO	YES
Asthma	NO	YES	**Circulation Problems**	NO	YES
Date Of Last Attack	_____		**Immunizations up to date?**	NO	YES
Attention Deficit Disorder	NO	YES	**Stomach Problems**	NO	YES

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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 minimun. 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 $75 fee charged to your account. Excessive "no-shows" or 3 or more cancelled appointments will be required to call or request appointment availabilty on the "day-of".
3. To prevent inconvenience to our "on-time" patients, "late" patients may need to be rescheduled, 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. 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.

Statement of Financial Policy

1. Fees are expected at the time services are rendered, unless other arrangements have bee 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. Insuarance covereage 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 and 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 day of service. Claims not paid within 30 days will automatically be 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.

_____

Patient Name (Print) Signature of Responsible Party Date