PIKE SMILES **SHARMILA SHYAMSUNDAR, DDS**

Name: _____ Preferred Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child Other : _____

Social Security #: _____ *Birth Date(MM/DD/YYYY):* _____

Phone (Mobile):_____(Home): _____ Email: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for **TODAY** visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy** Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Osteoporosis
☐ Codeine Allergy
☐ Penicillin Allergy

Others :
☐ _____
☐ _____

• Have you ever taken a Bisphosphonate, medication for treatment of osteoporosis or bone cancer. Commonly prescribed Bisphosphonates are: Fosamax (Alendronate), Actenol (Risendronate), and Boniva (Ibandronate), Zometa and Aredia ☐I have had osteoporosis or bone cancer but I'm not sure about the meds. ☐ Yes ☐ No

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

• Are you now under the care of a physician? ☐ Yes ☐ No Name of Physician _____
If yes, please explain: _____

• List of medications currently taken: _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Referral Information. We are a referral-based private practice. Thank you for your referral !

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ School ☐ Work ☐ Other _____

Name of person or office referring you to us : _____

Emergency Contact Name and Phone number : _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Insurance Company Name and Address : _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Insurance Company Name and Address : _____

Patient's relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services and Treatments

I consent to and authorize the performance of dental procedures by the Dentist or his/her assignee. I certify that the dental treatments recommended for me has been thoroughly discussed with me and that I clearly understand my dental treatment need, treatments options / alternatives, risks, benefits and consequences of no treatment. I am aware that some changes in the plan may become necessary during the course of treatment and I give my permission to the Dentist to make any and all changes and additions as necessary. I understand that I will need to comply with the Dentist's treatment related instructions.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services provided are charged directly to the patient and the patient is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms, assist in making collections from insurance companies or accept the benefit assignment , and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written financial arrangements are satisfied.

The fee estimate listed for the dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Dentist, I agree to pay therefore the reasonable value of services to the Dentist, or his assignee, at the time the services are rendered, or within ten (10) days of billing if credit shall be extended. I further agree that the reasonable value of services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have read the above terms and conditions, and I understand and agree to their content.

I also certify that I was given an opportunity to read and retain the HIPPA notices and the practice's general policies.

_____ _____ _____

Signature of patient, parent or guardian ***Relationship to patient*** ***Date***