PATIENT UPDATE FORM

DENTALWAYS

Better Smile • Better Health • Better Life

Dr. Denesh Khullar - Awarded as one of America's Top Dentists

Date _____Name _____Date of Birth _____

Marital Status _____ E-mail_____

Home Address_____ZIP_____

SS#_____ Cell #_____Home #_____

Emergency Contact_____ Phone Number_____ Relationship to pt_____

Medical History

To the best of your knowledge, are you or have you ever been under the care of a physician for any of the following? **(Circle all that apply)**

Anemia	**Angina**	**Arrhythmias**	**Arthritis/ Rheumatism**	**Artificial Heart Valve**
Artificial Joints	**Asthma**	**Blood Thinners**	**Blood Transfusion**	**Bypass Surgery**
Stents	**Cancer**	**Cold Sores**	**COPD**	**Defibrillator**
Diabetes	**Emphysema**	**Epilepsy/ Seizures**	**Excessive Bleeding**	**Fainting/Dizziness**
Glaucoma	**Healing Complications**	**Heart Disease**	**Heart Murmur**	**HIV/AIDS**
Hives/Rashes	**Irregular Heartbeat**	**Kidney Disease**	**Latex Allergy**	**Liver Disease**
Mitral Valve Prolapse	**Nervous Disorder**	**Organ Transplant**	**Osteoporosis**	**Pacemaker**
Currently Pregnant	**Psychiatric Care**	**Radiation/ Chemotherapy**	**Shortness of Breath**	**Sinus Infection**
Steroid Therapy	**Stroke**	**Tuberculosis**	**High Blood Pressure**	**Hepatitis B Hepatitis C**

Do you have any other health problems? Yes No

If so, please specify _____

_____

Are you currently under the care of a physician? Yes No

Reason _____

Name and phone number of physician? _____

Are you currently taking any drugs or medications? Yes No

If so, please list:_____

_____

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Have you had any surgeries? If so, please list _____

_____

Do you have any known drug allergies? Yes No

If so, please list _____

Do you use tobacco? Yes No If yes, how many years? _____

Do you vape? Yes No If yes, how many years? _____

I agree that I have provided my personal, medical, and dental history to the best of my knowledge. I further agree that I am the person financially responsible for my account. *If you are not financially responsible for your account we will need the signature of the person who is responsible for your account*

Printed Name_____

Signature_____

Date_____

HIPAA PATIENT CONSENT FORMS

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Dentalways has the right to change its Notice of Privacy Practices from time to time and that I may contact Dentalways at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME_____

SIGNATURE_____

DATE_____

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FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICES- WE ACCEPT CASH, CHECKS, AND CREDIT CARDS

REGARDING INSURANCE

We may accept assignment of insurance benefits after your second visit. However, we do require your estimated portion of the bill to be paid at time of services. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you make arrangements to take care of your balance by using one of our convenient payment methods. If your insurance company has not paid your account in full within 60 days, the balance will be automatically transferred to your credit card or one of our other payment options. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary by your Insurance Company. Regarding Insurance Plans where we are a provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

SCHEDULED APPOINTMENTS

I understand and agree to pay for the cost of the appointment I have missed if I have not provided Dentalways with a notice of my intention to cancel my appointment within twenty-four (24hrs) of my appointment time. I understand that my insurance coverage will not pay and will not be billed for missed appointments. There will be a fee of $50 applied to the account in the event that you do not contact us within 24hrs of the appointment to make other arrangements.

ADULT PATIENTS are responsible for full payment at time of service and for **MINOR PATIENTS,** The adult accompanying the minor/the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized for payment at time of service.

PATIENT UPDATE FORM

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy and I understand and agree to the conditions of this policy.

SIGNATURE OF PATIENT/RESPONSIBLE

PARTY_____DATE_____

SIGNATURE OF CO-RESPONSIBLE

PARTY_____DATE_____

SMS MESSAGES OPT IN

I consent to receive SMS text messages from Dental Ways (North Little Rock) for appointment reminders, marketing messages, and general two-way communication.

Msg frequency varies. Msg&data rates may apply."

Reply HELP for support. Reply STOP to opt out

See our privacy policy for more information." If on a website, the privacy policy should be linked, along with Terms & Conditions if available. If not on a website, explain how to find the privacy policy.

Consumer information is not shared with third-parties for marketing purposes.

SIGNATURE OF

PATIENT/PARENT/GUARDIAN_____

Name of

Patient/Parent/Guardian_____

DATE_____

RELATIONSHIP TO PATIENT_____