Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # ____________________

SS # ____________________

Date ____________________

PATIENT INFORMATION

Name ____________ Birthdate ____________ Home Phone ( ) ____________

Address ____________ City ____________ State ______ Zip ______

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

E-mail ____________ Cell Phone #1 ( ) ____________ Cell Phone #2 ( ) ____________

Employer/School ____________ Employer/School Phone ( ) ____________

Employer/School Address ____________ City ____________ State ______ Zip ______

Spouse or Parent's Name ____________ Employer ____________ Work Phone ( ) ____________

Whom may we thank for referring you? ____________

Person to contact in case of emergency ____________ Phone ( ) ____________

RESPONSIBLE PARTY

Name of Person Responsible for this Account ____________ Relation to Patient ____________

Address ____________ Home Phone ( ) ____________

Driver's License # ____________ Birthdate ____________ Bank ____________

Employer ____________ Work Phone ( ) ____________

Currently a patient in our office? ☐ Yes ☐ No E-mail ____________ Cell Phone ( ) ____________

INSURANCE INFORMATION

Name of Insured ____________ Relation to Patient ____________

Birthdate ____________ Social Security # ____________ Date Employed ____________

Employer ____________ Work Phone ( ) ____________

Employer Address ____________ City ____________ State ______ Zip ______

Insurance Company ____________ Group # ____________ Union or Local # ____________

Address ____________ City ____________ State ______ Zip ______

How much is your deductible? ____________ How much have you used? ____________ Max. Annual Benefit ____________

ADDITIONAL INSURANCE

Name of Insured ____________ Relation to Patient ____________

Birthdate ____________ Social Security # ____________ Date Employed ____________

Employer ____________ Work Phone ( ) ____________

Employer Address ____________ City ____________ State ______ Zip ______

Insurance Company ____________ Group # ____________ Union or Local # ____________

Address ____________ City ____________ State ______ Zip ______

How much is your deductible? ____________ How much have you used? ____________ Max. Annual Benefit ____________

- OVER -

DENTAL HISTORY

Reason for today's visit ______ Date of last dental care ______

Former Dentist ______ Date of last dental X-rays ______

Address ______

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? ______ How often do you brush? ______

MEDICAL HISTORY

Physician's Name ______ Date of last visit ______

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ______

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ______

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking and the correlating diagnosis: ______

Allergies: ______

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company(ies)

Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

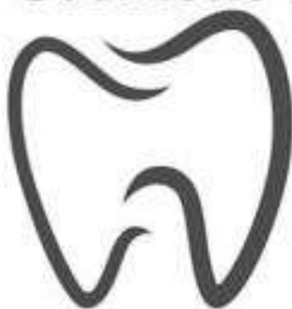
The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

______ Signature of Patient, Parent, Guardian or Personal Representative ______ Date

______ Please print name of Patient, Parent, Guardian or Personal Representative ______ Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Cosmetic & Family Dentistry



Recca Puri, DDS

(734) 847-1955

8339 Lewis Ave. Temperance MI 48182

Patients with Dental Insurance: As a courtesy to you, our office will gladly submit to your insurance. We are able to bill to all traditional, indemnity insurance plans. We do not accept DMO or DPO plans (Dental Maintenance or Dental Provider Organizations). Under these plans, there is no coverage when treatment is rendered by a non-participating dentist. Please check your type of plan carefully. Patients with Delta Dental Insurance: Dr. Puri is a participating "PREMIERE" provider (not PPO). However, for all PPO plans, even though Dr. Puri is out-of-network, we are still able to bill your insurance and benefits are payable. For more specific information about out-of-network benefit amounts, please call your insurance company.

Authorization to Release Info and Assignment of Benefits: I certify that I, ______________________________________,
(Or my dependent) have (has) dental insurance coverage and assign directly to Dr. Puri all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor and/or her staff to release all necessary personal information to my insurance company in order to secure the payment of benefits.

In the case of divorce: The patient seeking treatment of their child will be responsible for the payment of services. If this is an issue with the ex-spouse divorce decree, it will be the responsibility of the parent seeking treatment to resolve any issues with the ex-spouse. We cannot get involved with any divorce situation, nor should it be our responsibility to pursue payment from an ex-spouse.

Payments: We accept cash, check, VISA, MasterCard, and Discover. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot guarantee the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, 50%, etc.) on their own fee schedule, and not our office's actual fees, which may result in a balance due higher than expected. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. If a credit balance should result after insurance
processes your claim, a refund will be promptly issued to you.

Unpaid Insurance Claims: All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

Past-Due Accounts: If payment is not received by the due date printed on the statement, then your account is considered "past due". We reserve the right to charge a **$4.00** per month billing charge on all past due accounts. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency and/or our attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees that this office incurs while attempting to collect on the unpaid balance. These collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder. **If your account goes into collection Dr. Puri-patient relationship will be terminated. In the case of an emergency Dr. Puri will be available for 30 days from the date you are sent to collection. This includes all patients on the account.** Initial:____________

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00. Please help us to serve you better by keeping scheduled appointments.

Patients without Dental Insurance: Payment in full is expected at the time services are rendered. We accept cash, check, VISA, MasterCard, and Discover. If, however, payment is made with cash or check, a 5% discount is provided. We are unable to provide this discount if payment is made with a credit card.

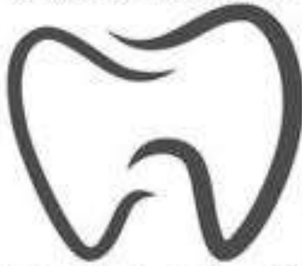
Our Office: no longer uses Amalgam (silver) as a filling material. We rely on, bonded adhesive dental materials that have proven to be more conservative than Amalgam. Unfortunately, some of the Insurance companies will make an allowance from a composite filling fee to an Amalgam fee. Insurance will basically pay what they would pay as if the restoration is Amalgam.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

Patient Name (print): ______________________________ Date: ______________________________

Signature: ______________________________ Relationship to patient: ______________________________

Cosmetic & Family Dentistry



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Patient Acknowledgement of Receipt of Notice of Privacy Practices and Consent/Limited Authorization & Release

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims

Date:________________________ Patient Name: ____

Please List any other parties who can have access to your health information:

(This includes step parents, grandparents (etc.) and any care takers who can have access to the patients records)

Name:___________________________ Relationship:________________Tel (____) _____ - _______

Name:___________________________ Relationship:________________Tel (____) _____ - _______

☐ Myself only, no other family members (please be aware that by checking this we will not be able to discuss appointment information with anyone but the patient.)

How our office will communicate with you in regards to your Oral Health

For your convenience, our office uses an automated system to confirm appointments. I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT, BILLING, AND (if sent to) COLLECTION. **INFORMATION MAY BE SENT VIA**: Cell, home, work, text, email and by mail.

Initial:_______ Primary phone # to be contacted at: (____) _____ - _________

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Rule, provide you this information with your knowledge and consent. I understand that I have access to or have reviewed Cosmetic and Family Dentistry *Notice of Privacy Practices* for the following medical practice:

8339 Lewis Ave. Temperance, MI Tel: (734) 847-1955
Privacy Official: Jona Hoffman-Office Manager

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

______________________________ Please PRINT name of patient

______________________________ Please SIGN for patient

______________________________ Legal Representative/Guardian

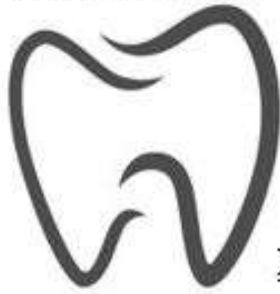
______________________________ Relationship of legal Representative/Guardian

OFFICE USE ONLY

As privacy officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- The patient was unable to sign because

Cosmetic & Family Dentistry



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X-Ray Release Form

Date: ___________

Office/Dr. _________________________, Office #_____________________

Fax #__________________________ Email _____________________________

Please be advised that recently ___________________________DOB __________

Attended our office and has decided to continue future treatment here.

The Patient kindly requested that you forward a copy of any dental treatment records, radiographs and any other information which may be pertinent to their treatment to our office. Please forward all information to:

info@bedfordmidentist.com

Please indicate the date of

Bitewing X-rays:___________________________________

Panorex X-ray or Full Mouth Series:__________________________________

Thank You,

Cosmetic & Family Dentistry

Recca Puri, DDS

Patients Signed Request_______________________________________Date_____________