Health History

1. Were you seen by a dentist in the last 6 months? YES NO
2. Do you have anxiety, fear, or stress about seeing the Dentist? YES NO
3. Are you under a physician's care? YES NO
   If yes, why _____
   Physician Name _____ Phone _____

4. List all current medications and the medical condition for which you are taking it

Medication	**Indication**

5. Are you currently taking, in the past have taken, or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia®, Boniva®, Reclast®, Prolia®) YES NO

6. Are you allergic to the following medicine? If yes, also state allergic reaction

Medicine	**YES**	**NO**	**Reaction**
Penicillin			
Other antibiotic(s) *(specify)*			
Codeine			
Other narcotic(s) *(specify)*			
Aspirin			
Latex			
Other*(specify)*			

7. Do you smoke/chew/snuff any Tobacco related products? YES NO
   If yes, how much _____ how often _____

8. Do you drink alcoholic beverages? YES NO
   If yes, how much _____ how often _____

9. Do you use controlled substances (drugs)? YES NO
   If yes, which substance(s)_____
   If yes, how much _____ how often _____

PIONEER DENTISTRY

10. Do you currently have or have a prior history of any of the following medical conditions?

Medical Condition	**Yes**	**No**	**Medical Condition**	**Yes**	**No**
High Blood Pressure			Epilepsy/Seizures *(specifiy)*		
High Cholesterol			Joint Replacement		
Heart Disease			Thyroid trouble *(specify)*		
Angina			Liver Disease		
Heart Attack			Hepatitis *(A, B, C or other)*		
Stroke ***(Ischemic, Hemorrhagic, TIA)***			Acid Reflux/Heart Burn		
Rheumatic Fever			Mental Health Concerns		
Pacemaker			AIDS or HIV		
Endocarditis			Herpes		
Asthma *(Allergic or Stress Related)*			Other STD's		
Emphysema			Arthritis		
Tuberculosis			Other condition(s) *(specify)*		
Diabetes Mellitus *(Type I or II)*			**For female patients ONLY:**		
Kidney Problems			Currently Pregnant		
Cancer *(specify)*			Week #: ____; Due Date: _____		
Anemia			Taking Oral Contraceptive		
Blood Transfusion			Nursing		

11. Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain.

_____

_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Patient Name Patient Signature Date

_____

Name of Parent/Legal Guardian Parent/Legal Guardian Signature Date

__Amit Kalavadiya _____

Name of Dentist Dentist Signature Date

Patient Information

1. Name: Last_____ First_____ Middle _____
2. Preferred First Name: _____
3. Title *(circle):* Mr. Mrs. Miss Ms.
4. Sex *(circle*): M / F
5. Date of Birth (mm/dd/yyyy): _____ / _____ / _____
6. Social Security Number: _____ - _____ - _____
7. Driver's License: _____ _____ _____
8. Home Address: _____

   City _____ State _____ Zip Code _____

9. Home Phone Number: _____ - _____ - _____
10. Cell Phone Number: _____ - _____ - _____ OK to send text: Y / N
11. Preferred Contact Phone Number: _____ - _____ - _____ OK to leave message: Y / N
12. Email Address: _____
13. Occupation: _____
14. Patient's Employer: _____
15. Work Phone Number: _____ - _____ - _____
16. Marital Status *(circle)*: Single Married Separated Divorced Widowed
17. Height: _____ feet _____ inches
18. Weight: _____ pounds
19. Student Status if Dependent over Age 19 for Insurance *(circle)*:
    a. Nonstudent Part-time Fulltime
    b. Name of College: _____

If Patient is a minor:

1. Mother's Name: Last_____ First_____ Middle ____
2. Mother's Date of Birth (mm/dd/yyyy): _____ / _____ / _____
3. Mother's Social Security Number: _____ - _____ - _____
4. Mother's Employer: _____
5. Mother's Work Phone Number: _____ - _____ - _____
6. Father's Name: Last_____ First_____ Middle _____
7. Father's Date of Birth (mm/dd/yyyy): _____ / _____ / _____
8. Father's Social Security Number: _____ - _____ - _____
9. Father's Employer: _____
10. Father's Work Phone Number: _____ - _____ - _____
11. **Name of Person Responsible for Account**: _____

Patient Information, cont'd

Emergency Contact Information:

1. Name: Last_____ First_____ Middle _____
2. Address: _____
   City _____ State _____ Zip Code _____
3. Telephone Number: _____ - _____ - _____
4. Relationship to Patient: _____

New Patients ONLY:

How were you referred to Pioneer Dentistry?	YES	NO
• Insurance Company		
• Pioneer Dentistry Website		
• Pioneer Dentistry Facebook® Page		
• Current Pioneer Dentistry Patient o Name: Last_____First_____Middle___ o Phone Number: _____-_____-_____		

Dental Insurance Information:

Primary Carrier

Insured's Name: Last_____ First_____ Middle _____

Insured's Date of Birth (mm/dd/yyyy): _____ / _____ / _____

Insurance Company Name: _____

Insurance Company Address: _____

City _____ State _____ Zip Code _____

Insured's Employer: _____

Insured's Social Security Number: _____ - _____ - _____

Group Number:_____ ID Number:_____

Patient Information, cont'd

Secondary Carrier

Insured's Name: Last_____ First_____ Middle _____

Insured's Date of Birth (mm/dd/yyyy): _____ / _____ / _____

Insurance Company Name: _____

Insurance Company Address: _____

City _____ State _____ Zip Code _____

Insured's Employer: _____

Insured's Social Security Number: _____ - _____ - _____

Group Number:_____ ID Number:_____

CONSENT: The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. In the event that payment expected from insurance is not received, I am responsible for the entire bill. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor. Should my account be turned over to collection, I agree to pay all costs and charges, including any attorney fees.

For your convenience, we accept cash, check, or credit cards (Visa, MC, American Express & Discover)

We reserve the right to charge a cancellation fee for appointments missed or broken without prior notice of 24 hours.

_____

Patient Name Patient Signature Date

_____

Name of Parent/Guardian of Minor Parent/Guardian Signature Date

Cancellation Policy

I am aware that once an appointment has been scheduled, I must provide Pioneer Dentistry with greater than 24hours notice should I need to reschedule or cancel my appointment for any reason.

Notification of less than 24hours for the need to reschedule or cancel the appointment or outright no show at the scheduled appointment time will lead to a **standard cancellation fee of $25.00** on your account to be paid within 30 days of missed appointment.

This policy had been in place at this location from the previous dental practice owner. In fact, a well-placed and visible sign has been in the patient reception area since that time as well, along with notification on the patient information form. Since the time ownership of the practice changed over 2 years ago, Dr. Kalavadiya had graciously forgone enforcement of this policy. Sadly, the number of patients who have repeatedly misused his kindness has gone well beyond reasonable limits. Additionally, Dr. Kalavadiya has staff that he must consider and provide best use of their time. Enforcement of the cancellation policy will be in effect as of January 2017. We appreciate your understanding, acceptance, and cooperation regarding this matter.

Patient Name	Patient Signature	Date

Name of Parent/Legal Guardian	Parent/Legal Guardian Signature	Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

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

I acknowledge that I have received your *Notice of Privacy Practice*, including security and breach notification policies and procedures, containing a more complete description of the uses and disclosures of my health information. I understand that I should ask this organization's Privacy Official if I have any questions about these policies and procedures. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization 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 my such restrictions.

Patient Name	Patient Signature	Date
Name of Parent/Guardian of Minor	Parent/Guardian Signature	Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (s*pecify*)_____