OPTUM DENTAL CARE
HITESH SHROFF, D.D.S.
General & Implant Dentistry

THANK YOU FOR SELECTING OUR DENTAL HEALTHCARE TEAM! WE WILL STRIVE TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE. TO HELP US MEET ALL YOUR DENTAL HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY IN INK. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE ASK US - WE WILL BE HAPPY TO HELP.

PATIENT INFORMATION (CONFIDENTIAL)

PATIENT # _____

DATE _____

NAME _____ BIRTHDATE _____ HOME PHONE _____
(Last) MI (First)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE _____ ☐ FULL TIME ☐ PART TIME

PATIENT OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT/GUARDIAN'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 _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

EMAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____ SS# _____

PAYMENT EXPECTED AT EACH VISIT _____ PATIENT INITIALS

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT. PLEASE CHECK THE OPTION YOU PREFER.

☐ CASH ☐ PERSONAL CHECK ☐ CREDIT CARD ☐ INTEREST FREE FINANCING

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ (SS#) _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ POLICY/ID # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

OVER PLEASE

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS WITHIN THE LAST 5 YEARS?	☐	☐
IF YES, PLEASE EXPLAIN. _____		
3. DO YOU USE CONTROLLED SUBSTANCES?	☐	☐
4. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES?	☐	☐
5. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LEVITRA IN THE LAST 24 HOURS?	☐	☐
6. DO YOU USE TOBACCO?	☐	☐
7. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		

	YES	NO
9. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?		
LOCAL ANESTHETICS (E.G. NOVOCAIN)	☐	☐
PENICILLIN OR ANY OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES	☐	☐
SEDATIVES	☐	☐
IODINE	☐	☐
ASPIRIN	☐	☐
ANY METALS (E.G. NICKEL, MERCURY, ETC.)	☐	☐
LATEX RUBBER	☐	☐
OTHER (PLEASE LIST) _____		
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING ORAL CONTRACEPTIVES?	☐	☐

8. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS	☐	☐
HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED	☐	☐
RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE	☐	☐
SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES	☐	☐
FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS	☐	☐
ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY	☐	☐
LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA	☐	☐
EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS	☐	☐
LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE	☐	☐
DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT.	☐	☐	HEART TROUBLE	☐	☐
KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS	☐	☐
AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	MITRAL VALVE PROLAPSE	☐	☐
THYROID PROBLEM	☐	☐	STOMACH TROUBLES / ULCERS	☐	☐	OTHER _____	☐	☐

PATIENT DENTAL HISTORY

NAME OF PREVIOUS DENTIST AND LOCATION _____ DATE OF LAST EXAM _____

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
12. DO YOU WEAR DENTURES OR PARTIALS?	☐	☐
IF YES, DATE OF PLACEMENT _____		
13. HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?	☐	☐
14. DO YOU LIKE YOUR SMILE?	☐	☐

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF MINOR) DATE

FORM 018611 R/07/15 ITEM 8101

PATIENT CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with **Optum Dental Care, LLC.,** "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Patient Name: *(please print)* _____

Patient Signature *(or legal representative; proof may be requested)* _____

Date: _____

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **Optum Dental Care, LLC., (ODCLLC)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **ODCLLC** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **ODCLLC** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **ODCLLC** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

Patient Acknowledgment & Agreement

My Consented Email Address is: _____

My Consented Mobile Number For Text Messaging is: _____

X _____ _____

Patient Signature **Date**

OPTUM DENTAL CARE
HITESH SHROFF, DDS
General Dentistry & Implants

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Patient Acknowledgment of Benefits

To avoid any misunderstanding regarding dental coverage through prepaid dental plans(i.e., Comp Benefits, American Dental Plan, Aetna Dental Plan, Delta Dental Plan, MIDA Dental Plan, SafeGuard Dental Plan, Signature Dental Plan, Denti-Care Dental Plan, Assurant Dental Plan, Atlantic Dental Plan, MCNA Dental Plan, Paramount Dental Plan),we have outlined some basic information below. Please read, sign and date this form, indicating you understand.

Prepaid dental plans ,dental maintenance organizations, offer its members a discount on dental fees. This is not dental insurance and prepaid dental plans do not pay the difference between the dentist's regular fee and the plans co-payments. Notification to this office of any coverage you may be entitled to must be provided prior to your first appointment.

All services requiring a co-payment by the patient must be paid for prior to date of service. In the event you have secondary dental coverage under another plan we will fill out your insurance form as courtesy. Our fees maybe above what your secondary carrier considers usual and customary. Our fees will not be discounted.

All procedures may not be specifically covered by a plan. Those procedures not listed on the co-payment schedules are performed at a 25% discount from the dentist's regular fee. We strongly suggest you become familiar with your plan benefits and scheduled of co-payments , especially the portion concerning broken or missed appointments and the charges associated with them. There may be additional charges for laboratory work, as indicated by your plan. This office does not issue refunds; a credit will be issued and applied to future treatment. Refunds, when applicable, will be issued in not less then thirty (30) days from the date of receipt. If payment was by credit card, any refund will be by the same credit card less a $35.00 handling fee. There will be no refunds for deposits on laboratory work. Duplication of x-rays or records must be prepaid at our standard duplicating fee.

At the recommendation of the Centers for Disease Control(C.D.C.) our office has chosen to subscribe to and implement useful, scientifically-proven and effective infection control procedures. At the subscriber's option, a non-covered, separate fee will be charged each office visit to help defray a portion of the extra costs incurred for infection control materials, procedures, equipment and techniques. Currently, this fee is noted as an office visit fee or infection control fee per office visit and is payable at each appointment. By affixing your signature below, you agree to be charged and to pay this fee to assist us in helping to defray our costs for your protection.

In the event of cancellation or termination of your plan within the minimum contract period, usually one year, all previous benefits are lost and you are responsible for payment of the dentist's regular fee for all services performed during the covered period.

In the event you find it necessary to change or to cancel a scheduled appointment, a minimum of 24-hours advance notification to this office is required by your pre-paid dental plan. A signed voucher from a valid major credit card company must be completed prior to scheduling an appointment with the dental hygienist for a prophylaxis(teeth cleaning) appointment for which there is no co-payment fee assessed by your pre-paid dental plan. If no timely notice of cancellation is given or if you do not appear on time for your appointment, your plan assesses you a 'broken appointment' charge which you are responsible to pay prior to making any additional appointments or receiving further plan benefits.

Please note, all co-payments must be paid at the time services are rendered. If, for any reason, a plan member has an outstanding balance, no further services will be rendered until the outstanding balance is paid. If a balance is owed, you will be unable to transfer from this officer to another dentist.

We hope that by following these simple policies any confusion or misunderstanding can be kept to a minimum.

I acknowledge that I have read, understand and accept the above benefits of my pre-paid plan.

Signature: _____ Date: _____