

Welcome! Thank you for selecting our dental team! We always live by our mission:

"To provide the highest quality dental care in the most comfortable environment possible"

To help us better serve you, please fill out these forms for us. Thank you for your cooperation.

Dr. Ashish C. Patel & Team

About You

Today's Date: _____

Name: _____ Preferred Name: _____ Birth Date: _____
Last First MI

SS #: _____ Male Female Marital Status: Minor Single Married

Home Address: _____ City/State: _____ Zip: _____

Employer: _____ Your Occupation: _____

How did you hear about our office? _____

Contact Information

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Pager #: _____ Email: _____ Fax #: _____

In case of emergency who should be notified? Name: _____ Phone: _____

****Dentistry at East Piedmont sends reminders via email/text messaging before each reserved appointment unless otherwise advised****

Responsible Party

Person Responsible for Account: _____ Relation to Patient: _____

Date of Birth: _____ S.S. #: _____ Driver License #: _____

Address: _____ City/State: _____ Zip: _____

Insurance Information

Dental Coverage Yes No - If no, skip to next section

Insurance Company: _____ Insurance Phone #: _____ Group #: _____

Insured/Employee's Name: _____ Insured's Date of Birth: _____ Relation to Employee: _____

Insured/Employee's SS#: _____ Insured's Employer: _____

****Please note that the insured is the primary cardholder on the insurance card.****

Dental History

Previous Dentist: _____

Last dental visit? _____ Last Full Mouth X-rays? _____

How many times a day do you brush? _____ Floss? _____

Do you use an electric toothbrush? _____ Type? _____

Do your gums bleed when brushing? _____

Toothpaste Type? _____ Mouthwash Type? _____

Do you suffer from bad breath? _____

Are you in any type of dental pain? _____

Are any of your teeth sensitive? _____ When? _____

Do you grind/clench your teeth? _____

Do you wake up with soreness to your jaws? _____

Have you ever had gum disease therapy or deep cleaning?
If so, describe: _____

Would you be interested in cosmetically replacing older dark
fillings with new tooth colored restorations? _____

Would you like your teeth to be whiter? _____

Are you deeply concerned about the finances required to return
your mouth to excellent dental health? _____

If you had a magic wand and could change anything about your
smile what would you change? _____

Medical History

Physician's Name: _____ Date of Last Visit: _____

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

Has a doctor told you that you need antibiotics to premedicate for dental work? Yes No

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Please check all of the following you have had or have currently:

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling (feet/ankles) |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Fainting | <input type="checkbox"/> Jaw Pains | <input type="checkbox"/> Skin Rash | |

Allergies: _____ Medication (currently taking) _____

We offer these amenities to make your dental visit comfortable:

Personal CD-player/DVD Movies during your treatment
Soft Blanket to keep you warm during your visit with us

A paraffin wax treatment to soften and moisten your hands
A chair massage pad that will massage your back

Describe your past dental experiences: (in previous dental offices)

- | | |
|--|--|
| <input type="checkbox"/> Was the treatment comfortable? _____ | <input type="checkbox"/> Were the fees explained clearly prior to your appointments? _____ |
| <input type="checkbox"/> Was the staff friendly? _____ | <input type="checkbox"/> Was treatment explained to you thoroughly prior to your appointments? _____ |
| <input type="checkbox"/> Were you seen in a timely manner? _____ | |

Authorization and Release

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 I am financially responsible for all charges whether or not paid by insurance. I authorize the release of any information, including the diagnosis and records of treatment/examination rendered, to my insurance company and other healthcare providers as necessary.

Photographic Release

In our office, photographs may be taken of our patients for aid in determining proper diagnosis and to help visualize with the appropriate treatment options. I hereby authorize Dentistry at East Piedmont to take photographs of my face, jaws, and teeth.

I understand that the photographs will be used in a record of my care and may be used for educational purposes.

Our Commitment to You

We are so pleased you have chosen us to be your dental provider. We do not overbook the schedule and your appointment time is reserved exclusively for you. One of THE main complaints we have heard from patients is that their previous dentist kept them waiting for hours in the waiting room or the dentist rushed in and out and was on roller skates for the entire day. We commit to respecting your time and all we ask is that you give us 2 business days notice prior to relocating your appointment. Please keep in mind our business week is Monday through Thursday.

All missed appointments with less than 2 business days notice will incur a \$50 fee.

Please Sign: I understand and agree to all of the above

Signature

Date

Thank you for taking the time to assist us in getting to know you and your dental needs. Dr. Patel and Team