PATIENT IS RESPONSIBLE FOR ANY REMAINING BALANCE DUE IN THE EVENT OF NON-INSURANCE COVERAGE OR CANCELLATION UNLESS OTHERWISE PREARRANGED WITH DR. PAI OR DR. DESAI.
PATIENT IS RESPONSIBLE FOR ANY DISPUTE PERTAINING TO THEIR COVERAGE WITH THEIR INSURANCE CARRIER. DR. PAI'S & DR. DESAI'S OFFICE IS NOT RESPONSIBLE SHOULD COVERAGE BE OTHER THAN PATIENT'S PRESENTATION OF INSURANCE AT TIME OF TREATMENT.

______________________________________ _____/_______/____
PATIENT, PARENT OR GUARDIAN SIGNATURE TODAY'S DATE

* **PLEASE FILL THE COMPLETE FORM ON BOTH THE SIDES AND PRESENT INSURANCE CARD WITH THIS FORM**

PATIENT INFORMATION

Patient Name ________________ ________________ ________________ **Date Of Birth** __ __ /__ __/__ __
First Name Middle Initial Last Name mm dd yy
Sex M______F_________ **Patient's Soc.Sec. #** ________________
Address ________________ ________________ ________________ Apt ______________________
City ________________ State______________ Zip Code___________ Cell Phone( )_____________
Employer ____________________ Home/Work Phone__________ ____________________

E-mail address ____

Dental Insurance :
Insurance Carrier ____________________ Group Plan# ____________________ Policy # ____________________
Secondary INS. ____________________ Group Plan # ____________________ Policy #____________________

IF UNDER 18 Parent or Guardian's Name __________________ __________________
Parent or Guardian Soc.Sec# __________________ Your relation to Responsible party Self ☐ Spouse ☐ Child☐ Other __________________

RESPONSIBLE PARTY INFORMATION (CHECK IF SAME AS ABOVE ☐)

please note that a minor cannot be a responsible party

Name ________________ ________________ ________________ Date Of Birth __ __ /__ __/__ __
First Name Middle Initial Last Name mm dd yy
Sex M______F_________ Soc.Sec. # ________________
Address ________________ ________________ ________________ Apt ______________________
City ________________ State______________ Zip Code___________ Home Phone( )_____________
Employer ____________________ Work Phone ____________________

INSURANCE SUBSCRIBER INFORMATION

CHECK IF SAME AS PATIENT ☐ CHECK IF SAME AS RESPONSIBLE PARTY ☐

Name ________________ ________________ ________________ Date Of Birth __ __ /__ __/__ __
First Name Middle Initial Last Name mm dd yy
Sex M______F_________ Soc.Sec.. # ________________
Address ________________ ________________ ________________ Apt ______________________
City ________________ State______________ Zip Code___________ Home Phone( )_____________
Employer Name ____________________ Work Phone ____________________

Dental Insurance :
Insurance Carrier ____________________ Group Plan # ____________________ Policy # ____________________
Secondary INS. ____________________ Group Plan # ____________________ Policy #____________________

Dependent Information ;(Spouse and Children not listed)

Name	Birth Date	Relationship

Patient Name ____________________Soc. Sec#_________________ Home Phone______________________

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?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine, or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐

7. Are you allergic to or have had any reaction to the following :

	YES	NO		YES	NO
Local anesthetics	☐	☐	Iodine	☐	☐
Penicillin	☐	☐	Sedatives	☐	☐
Sulfa Drugs	☐	☐	Aspirin	☐	☐
Barbiturates	☐	☐	Other _______________ (please specify)		

8. WOMEN ONLY

A. Are you pregnant or think you are? ☐ ☐ B. Are you nursing? ☐ ☐

C. Are you taking birth control pills? ☐ ☐

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

	YES	NO		YES	NO		YES	NO	Comments
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Stomach troubles	☐	☐	
Heart Attack	☐	☐	Cardiac pacemaker	☐	☐	Chest Pains	☐	☐	________
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Easily winded	☐	☐	________
Swollen Ankles	☐	☐	Angina	☐	☐	Stroke	☐	☐	________
Fainting Seizures	☐	☐	Frequently tired	☐	☐	Hay Fever/Allergies	☐	☐	________
Asthma	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	________
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Radiation therapy	☐	☐	________
Leukemia	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐	________
Kidney disease	☐	☐	Arthritis	☐	☐	Recent Weight loss	☐	☐	________
Aids or HIV infection	☐	☐	Joint Replacement	☐	☐	Liver Disease	☐	☐	________
Thyroid problems	☐	☐	Joint Implant	☐	☐	Respiratory Disease	☐	☐	________
Diabetes	☐	☐	Hepatitis/Jaundice	☐	☐	Other Please Specify	☐	☐	________
Epilepsy/Convulsions	☐	☐	Sexually Trans. Disease	☐	☐	____________________			

PATIENT DENTAL HISTORY

	YES	NO		YES	NO
1.Do your Gums bleed while brushing or flossing?	☐	☐	7.Do you have frequent headaches?	☐	☐
2.Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	8.Do clench or grind your teeth?	☐	☐
3.Do you feel pain to any of your teeth?	☐	☐	9.Do you bite your lips or cheeks frequently?	☐	☐
4.Do you have any sores or lumps in or near your mouth?	☐	☐	10.Have your ever had any difficult Extractions in the past?	☐	☐
5.Have you had any head, neck or jaw injuries?	☐	☐	11.Have you ever had prolonged Bleeding following extractions?	☐	☐
6.Have you ever experienced any of the following problems in your jaw?			12.Have you had any orthodontic work?	☐	☐
• Clicking?	☐	☐	13.Have you ever had instructions on correct method of brushing of your teeth and on the care of your Gums?	☐	☐
• Pain(joint, ear, side or face)?	☐	☐			
• Difficulty in opening or closing?	☐	☐			
• Difficulty in chewing?	☐	☐			

Signature: I certify that I have read and understood the above information. I have accurately answered the above questions to the best of my knowledge and I understand that providing incorrect information can be dangerous to my health and authorize work.

x____ Date_____ ________________________________