Vijay Patel, DDS
19007 Bruce B. Downs Blvd,
Tampa, Fl 33647

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Address: _____
Street City/State Zip code

Gender: (M or F) ____ Marital Status: Single Married Divorced Widowed

Social Security #: _____DOB: _____ Email: _____

Phone (Home) _____ Phone (Work): _____Ext: ____ Cell # _____

Best time to call _____ Occupation: _____

Whom may we thank for referring you? _____ Phone _____

Emergency Contact Name: _____Phone_____ Relation _____

Insurance Information

Subscriber Name _____ SS#_____ DO**B** _____

Insurance Company _____ Group Number _____ Phone _____

Mailing Address _____ Employer _____

Effective Date _____ Coverage: Individual _____ Spouse _____ Children _____

Responsible Party

Person responsible for the account _____ Relationship _____

Address: _____
Street City/State/Zip Code

Home Phone # _____ Work # _____ Cell # _____

Health Information

Physician_____ Telephone # _____ Date of Last Exam: _____

Have you ever had any of the following?

	Yes		Yes		Yes		Yes
AIDS/HIV Positive		**Epilepsy**		**High Blood Pressure**		**Pacemaker**	
Anaphylactic Rxn		**Excessive Bleeding**		**Jaundice**		**Radiation Treatment**	
Anemia		**Fainting**		**Joint Replacement**		**Respiratory Problems**	
Arthritis		**Glaucoma**		**Kidney Disease**		**Rheumatic Fever**	
Artificial Joints		**Head Injuries**		**Liver Disease**		**Sinus Problems**	
Asthma		**Heart Attack**		**Lung Disease**		**Sexually Transmitted Disease**	
Cancer		**Heart Disease**		**Mental Disorders**		**Stroke**	
Chest Pain		**Heart Murmur**		**Mitral Valve Prolapse**		**Tuberculosis**	
Diabetes		**Hepatitis**		**Nervous Disorders**		**Ulcers**	

Have you ever been hospitalized for any serious illness within the last two years? If yes, please explain _____

_____

Are you taking any medication(s) including non-prescription medicine? If yes, please List: _____

_____

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Are you allergic to or have you had any reactions to the following?

☐ Aspirin ☐ Penicillin or other Antibiotics ☐ Codeine ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Acrylic

☐ Others: Please explain: _____

Do you need to pre-medicate before your appointments? _____

Do you use tobacco? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No

Women Only:

a) Are you pregnant or think you may be pregnant: ☐ Yes ☐ No If yes, Due date: _____

b) Are you nursing? ☐ Yes ☐ No c) Are you taking oral contraceptives? ☐ Yes ☐ No

Patient Dental Information

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays_____

Previous Dentist Name: _____ Telephone _____

Address _____City_____State_____Zip_____

Why did you leave your previous dentist? _____

How frequently do you brush your teeth? _____

Do you use a soft or hard bristle toothbrush? _____

Yes No Do you have any concerns regarding your teeth?

Yes No Have you lost any teeth?

Yes No Do you clench or grind your teeth?

Yes No Do you have any tooth, jaw, or muscle discomfort?

Yes No Do you have frequent headaches?

Yes No Do you have a click, pop, or other noise in the jaw joint?

Yes No Are your teeth sensitive to hot or cold?

Yes No Are any of your teeth uncomfortable to bite on?

Yes No Do your gums bleed when brushing or flossing your teeth?

Yes No Would you like information on whitening your teeth?

Yes No Are you interested in knowing cosmetic bonding or straightening your teeth?

Yes No Do you have any old fillings or dental treatment that you are unhappy with?

Is there anything else about having dental treatment that you would like us to know? ☐Yes ☐ No
If yes, please explain: _____

_____

I hereby authorize the release of any information, including the diagnosis and records of any treatments, x-rays, photographs, or examinations rendered, to my insurance company. I hereby authorize my insurance company to pay directly to Pebble Creek Family Dentistry any proceeds payable under the terms of my insurance policy. I understand that I am responsible for my dental bills. I hereby authorize Pramukh Dental Practice, P.L.L.C. d/b/a Pebble Creek Family Denstistry and Vijay Patel, D.D.S. to perform dental procedures on me, my minor children and/or family members. I will inform Dr. Patel of any changes in my health.

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

_____
Please print name of Patient, Parent, Guardian or Personal Representative

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Insurance & Financial Policy

Patient Name: _____ DOB: _____

Welcome… and thank you for choosing us as your dental provider. It is important to us that you understand and are comfortable with our fees, services, and financial policies. We will be happy to answer any questions or concerns you may have.

Payment Options

We offer a 5% discount on fees exceeding $300 paid in full with cash or check.
We accept Visa, MasterCard, Discover, and American Express.
We also offer third party financing through Care Credit. (Ask our Financial Coordinator)
We require ½ of your payment initially and ½ upon delivery on all major dental treatment.
All remaining portions of dental fees must be paid upon receipt of your statement.

Dental Insurance

It's wonderful that you have dental insurance to help cover part of the cost of your dental care. We want to cooperate with you to make the most effective use of your insurance benefits. We accept assignment of insurance benefits; however, we do require your estimated portion of the bill to be paid at the time of service. The remaining balance of the account is your responsibility. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract, but will help with any questions you have regarding your insurance benefits.

Insurance policies vary greatly in their benefits to its patients. Generally, the more you and your employer pay for the insurance, the more the insurance benefits will cover the dental services. Please be aware that some of your needed treatment may be non-covered services and not considered necessary by your insurance company. It is possible your insurance company will not pay 100% of their share of the fee.

Co-Payment / Co-Insurance / Deductible Information

I understand that my insurance company may require co-pay for each visit. I have been informed of this policy and understand that I am responsible for this co-payment at the time of service.
I understand that my insurance company may cover reasonable and customary charges and that I am responsible for the remaining reasonable and customary charges. This estimated amount is based on information we have received from your insurance carrier and may change when paid by your insurance carrier. I understand that my final balance will result after all claims for rendered services have been submitted. I have been informed of this policy and understand that I am responsible for this co-insurance.
I understand that my insurance company may require that I pay a deductible before my insurance company begins to pay for services rendered. I have been informed of this policy and understand that I am responsible for the deductible.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I agree that I have received a copy of the Notice of Privacy Practices from Pebble Creek Family Dentistry.

Non-Solicitation

As a former patient of Care Dentistry Group, PA or Florida Dental Practice, LLC, I have not been solicited by Pebble Creek Family Dentistry to terminate my relationship with either of the aforementioned dental practices.

We hope this clarifies our office procedure regarding payment arrangements. If you have any questions, please feel free to ask our Financial Coordinator. Thank you for your support and cooperation.

I, the undersigned, have read and understand the conditions listed above with respect to consent for treatment, release of information, insurance, and financial responsibility if it has not yet been met.

_____ _____

Signature of Patient or Guardian / Print Name Date