PROACTIVE Dental

Dr. Sabita Saha, BDS, DDS

Welcome!

About You

Today's Date: _____/_____/_____

Name: _____ **Preferred Name:** _____

Birthdate: _____/_____/_____ **Age:** _____ **Social Security #:** _____-_____-_____

Cell #: _____ **Alternate Phone #:** _____

Address: _____**City**: _____ **Zip Code**: _____

Email Address: _____ **Referred by:** _____

Status (circle one): (Married) (Single) (Divorced) (Separated) (Widowed) **Spouse's Name:** _____

Insurance Information

Insurance Company: _____

ID # _____ **Group #:** _____

Primary Insurance Holder (if not self): _____**Their DOB**: _____/_____/_____

Patient Signature: (_____) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company (if offered at this office)

Emergency Contact

Name: _____ **Relation**: _____

Phone Number: _____

ProActive Dental
Dr. Sabita Pyne Saha BDS, DDS
5933 Dallas Pkwy Ste. 100
Plano, Texas 75093

Dental Information

Reason for Today's Visit (circle): (Exam) (Emergency) (Consultation) (Cleaning and Preventive Care)

Are You in Pain (circle)? Yes No If So, How Long and Where: _____

Please Circle if You Have Any of the Following:

- ◯ Jaw discomfort, clicking, popping jaw, lock jaw
- ◯ Red, swollen, bleeding gums
- ◯ Sensitive teeth or gums
- ◯ Blisters/sores
- ◯ lost/broken fillings
- ◯ teeth grinding
- ◯ bad breath
- ◯ broken/chipped teeth

Do you Require Premedication for Dental Treatment(circle)? Yes No Unsure

Date of Last Dental Cleaning/Exam: _____

Last Dental Office: _____**How Often Do You Brush?** _____ **Floss?** _____

Do You Use Tobacco or Electronic Cigarettes (circle)? Yes No

Medical information

Please List Any and ALL Medications You Are Currently or Have Been Recently Taking:

_____

_____

_____

_____

Please Mark the Circle If You Have Any of the Following:

Heart Attack/ Stroke	Glaucoma	Back Problems	Jaw Problems/ TMJ
Heart Surgery/ Pace Maker	Bleeding Problems	Tuberculosis (TB)	Anemia
Heart Murmur	Thyroid Problems	Cancer/ Tumors	Cosmetic Surgery
Rheumatic Fever	Kidney Problems	Chemotherapy	Xray/ Cobalt Treatment
Mitral Valve Prolapse	Liver Problems	Hepatitis	Shingles
Artificial Valves	Respiratory Problems	HIV/AIDS/ARC	Asthma
Heart Disease	Sinus Problems	Arthritis/Rheumatism	Difficulty Breathing
Congenital Heart Defect	Stomach Problems/Ulcers	Artificial Joints/Bones	Diabetes
Chest Pains	Psychiatric Problems	Emphysema	High/Low Blood Pressure
Scarlet Fever	Venereal Disease	Seizures/Epilepsy/Fainting	Multiple Sclerosis
Nervousness/ Anxiety	Alcohol/ Drug Abuse	Severe/Frequent Headaches	

Other: _____

Continue on Next Page ➡

Medical History Continued

Please List Any Other Medical Conditions or Surgeries You Have (had):

_____

_____

_____

_____

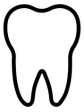
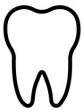
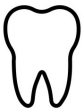
Please Circle if You Are Allergic to Any of the Following:

(Latex) (Penicillin/Amoxicillin) (Tetracycline) (Aspirin) (Dental Anesthetics)

Please List Any Allergies to Drugs/Food/Etc.:_____

Have You Ever Taken Phen-fen and or Redux? (circle): Yes No

Women: Are you Currently Pregnant or Breastfeeding? _____

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between patient and provider

Our policy requires payment in full for all services at the time of the visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

I authorize the staff to preform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form is completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of changes to the information I have provided.

Signature: _____ Date: _____

(Please Indicate Here if Signing on the Behalf of Someone Else) _____

Disclosures

For Treatment: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share dental information about you to your other health care providers to assist them in treating you.

For Payment: We may use an disclose your dental information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your dental information.

For Health Care Operations: We may use and disclose your dental information for our health care operations. This might include measuring and improving quality, evaluating and performance of employees conducting training programs, and getting the accreditation, certifications, licenses, and credentials we need to serve you.

Additional Uses and Disclosures: In addition to using and disclosing your dental information for treatment, payment, and health care operation, we may use and disclose dental information for the following purposes:

Notification: We may use and disclose dental information to notify or help notify: a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible before we share or give you the opportunity to refuse permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, dental supplies, x-ray to other dental information about you

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of dental information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the dental information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use dental information for military personnel or veterans, for nation security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State for correctional institutions and other law enforcement custodial situations, and for the government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose dental information in response to court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena we may share your dental information with law enforcement officials. We may share limited information with a law enforcement official concerning the dental information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the dental information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your dental information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may disclose your dental information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects to enable recalls, repairs, or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use or disclose dental information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your dental information if it is necessary to prevent a serious threat to your health or safety or the health and safety of others. We may share dental information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose dental information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose dental information to an agency providing health oversight, to activities authorized by law, including audits, civil administrative, or criminal investigations or proceedings, inspections, licensure, or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose dental information to law enforcement officials. These circumstances including reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement officials, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises and emergencies

Appointment Reminders: We may use and disclose dental information for the purposes of sending your appointment reminders or discussing pending treatment.

Alternative and Additional Dental Services: We may use and disclose dental information to furnish you with information about health-related benefits and services that may be of interest to you to describe the recommended treatment alternatives.

Your Individual Rights:

- You have a right to look at or get copies of certain parts of your dental information. You may request that we provide copies in a format other than photocopies. We will use the format requested unless it is not practical for us to do so. You must make your request in writing. Contact us for records at our office.
- You have a right to receive a list of all items we or our business associates shared your dental information for purposes other than treatment, payment, and health care operations and other specific examples.
- You have a right to request that we place additional restrictions on our use or disclosure of your dental information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement in the case of an emergency.
- You have a right to request that we communicate with you about your dental information by different means or to different locations. Your request that we communicate your dental information to you by different means or at different locations must be made in writing to us.
- You have a right to request that we change certain parts of your dental information. We may deny your request if we did to create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be accepted to the information that that you wanted changed. If we accept your request to change the information, we will make reasonable effort to tell others, including people you name, of the change and to include the changes in the future sharing of the information.

Questions and Complaints: If you have any questions about this notice or if you think we may have violated your privacy rights please contact us. You may contact us to submit a complaint or submit requests involving any of your rights. You may submit a complaint to the U.S department of Health and Human Services.

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully:

Our Pledge Regarding Dental Information:

The privacy of your dental information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our dental office. We need this record to provide you with quality care and to comply with certain legal requirements. These notices will tell you about the ways we may use and share dental information. Throughout these notices we refer to your medical information as dental information.

Our Legal Duty:

The Law requires us to: 1. Keep your dental information private 2. Give you notices describing our legal duties, privacy practices, and your rights regarding your dental information. 3. Follow the terms of the current notices.

We Have the Right to:

1. Change our privacy practices and the terms of these notices at any time, provided that the changes are permitted by the law.
2. Make the changes in our privacy practices and the new terms of our notices effective for all dental information that we keep, including previously created or received before the changes.

Notice of Change to Privacy Practice:

1. Before we make an important change in our privacy practices, we will change this notice and make a new notice available upon request.

Use and Disclosure of Your Dental Information:

The following section describes different ways that we use and disclose dental information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose dental information. We will not use or disclose your dental information for any purpose not listed above, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by contacting us.

Disclosures and Privacy Practice Acknowledgement

Acknowledgment: I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

X_____

Print Name Date

X_____

Signature (please indicate if personal representative signature) Date

Individual Patient's Authorization

This Section Allows Us to Share Your Dental and Medical Information for Specific Purposes (referrals to other dentists or medical doctors, formally requested family members, etc.)

I give my authorization to use or disclose my protected medical/dental information as described above. I give this information voluntarily. I understand that I may revoke this authorization at any time by giving written notice to us. However, I understand that I may not revoke this authorization as for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy. I understand that under most circumstances a dental care provided may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that by signing an authorization that permits the use and/or disclosures of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-relayed treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for the disclose of a third party. Under some circumstances, a health plan may condition enrollment in a health plan or my eligibility for benefits on my providing an authorized permitting the health plan to make enrollment and eligibility determinations. I understand that information disclosed under this authorization may be redisclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient rediscloses my health information.

X_____

Print Name Date

X_____

Signature (please indicate if personal representative signature) Date

Is there anyone currently you would like us to share your dental information with if requested? If so, please list here:

Name of individual who can receive your information: _____

Relation: _____ Their Phone Number: _____-_____-_____

Financial Agreement

At ProActive Dental, we believe that you deserve the best care. That's why we always present you with the best dental solutions possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't.

Your dental benefits are based upon a contract made between your employer and insurance company. **If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of all your dental care needs, it if only meant to assist you.**

We currently accept all private care (PPO) insurances. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your exact insurance benefit, we will be happy to file a "pre-authorization" with your insurance company prior to treatment. This does delay treatment but it will give you an exact out of pocket figure from your insurance company.

Many people receive notification from their insurance company that dental fees are "above usual and customary". An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are disclosures dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary".

We will bill your insurance as a courtesy. If insurance does not pay within 90 days, ProActive Dental reserves the right to request payment in full for serves from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part f that legal contract. Ultimately, you are responsible for all changes incurred in our office.

ProActive Dental does require payment in full for your portion at the time of services. We accept all major credit cards and cash payments. We no longer accept checks; we are sorry for the inconvenience. If you are in need of an extended financial option, we offer CareCredit applications who offer extended financing with zero interested for a given term.

Missed/Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. <u>All appointments that are missed or cancelled with less than 24-hour notices will results in a $35/hour fee.</u>

After Hour/Weekend Emergencies: In the event of an emergency after regular business hours a **$100 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$150 for an after-hours emergency fee**.

We welcome you to our facility and look forward to helping you get healthy, beautiful smiles. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask any of our team members.

X_____

Print Name Date

X_____

Signature (please indicate if personal representative signature) Date

You have a right to a copy of these forms after signing.