NEW HORIZONS DENTAL

General and Cosmetic Dentistry

Savitha Harapanahalli, D.M.D

Patient Name: ___________________________________
(First) (Middle) (Last)

Preferred Name: _________________________________

Address: _______________________________________
(Street)

____
(City) (State) (Zip)

Cell Phone: _____________________________________

Work Phone: ____________________________________

Home Phone: ____________________________________

E-Mail: ____

Preferred Method of Contact:

□ Cell □ Text □ E-Mail □ Home □ Work

Date of Birth:____________ Gender: □Male □ Female

SS#: ____________________ DL #: _________________

Emergency Contact: ______________________________

Number: __________________ Relationship: __________

Responsible (or Insured) Party Information:

Name: ____

Date of Birth: ___________Employer:________________

SS#: _____________________ Ins. Co.: ______________

ID # :_____________________ Group #:______________

Who May We Thank For Your Referral?

____

Dental Treatment Consent

1. **Health Information:** I agree to disclose all previous illnesses and medical history. Undisclosed medical information and current medication, allergies or illness are risk factors
2. **Drugs, Latex, and Medicines:** I understand that antibiotics and other medicines can cause allergic reactions and even life threatening anaphylaxis. Also, some antibiotics interfere with birth control pills. Latex allergy can cause rashes and itching. Epinephrine increases heart beat and depending on my health may be dangerous to me. I also understand that Dr. Hara can not call in a medication for me unless I have been seen in her office so that she may evaluate the issue I am having.
3. **Needle Stick:** If someone is inadvertently stuck with a needle or instrument used on me, I consent to have blood drawn for an analysis.
4. **Fee for Additional or Specialty Care:** I understand that I may need treatment beyond what was originally planned (i.e. a filling was placed but the tooth fractures may need a crown), or I may be referred to a specialist for additional care (i.e. a crowned tooth becomes painful will need a root canal). **I agree to be financially responsible for the additional or specialty care.**
5. **Late Arrivals: I understand that appointment times are reserved for each patient and that by arriving late I will receive less than my allotted time. I agree that if I am going to be more than 10 minutes I will call the office to ensure that they will be able to complete the service I was scheduled for. I understand that if I arrive more than 15 minutes after my appointment time I may not be able to have some or all of my services performed and I will be asked to reschedule to complete them.**

I do not expect guarantees in dental care. I have read the above and consent to treatment. I have also received and read a copy of the office HIPAA Policies.

_______________________________ _______________ __________
(Signature of Patient or Parent if Minor) (Date) (Witness)

Time 9:42 AM | New Horizons Dental | Date 9/4/2019

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	If yes
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? ◯ Yes ◯ No If yes

Do you have, or have you had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:___________

Time 9:47 AM | New Horizons Dental | Date 9/4/2019

Dental History

Patient Name: Birth Date: Date Created:

Dental History

When was your last dental visit?____________________ Was it for a cleaning?________________

Question	Answer	
Have you ever received Orthodontic treament	◯ Yes ◯ No	If yes
Have you ever seen a Periodontist (Gum Specialist)?	◯ Yes ◯ No	If yes
Have you been advised to take antibiotics prior to dental treatment?	◯ Yes ◯ No	If yes
Have you ever had a complication or severe reaction to dental anesthetic? If yes what was the reaction?	◯ Yes ◯ No	If yes

Do you use a manual or electric tooth brush? _________________

How often do you Brush? ____________________ How often do you floss?______________________

General Health of Teeth

Do you have, or have you had?:

Difficulty chewing your food?	◯ Yes ◯ No	Chew only on one side of your mouth?	◯ Yes ◯ No	Catch food between your teeth?	◯ Yes ◯ No
An uncomfortable bite?	◯ Yes ◯ No	Gums that bleed when brushing or flossin	◯ Yes ◯ No	Sensitivty to HOT?	◯ Yes ◯ No
Sensitivty to COLD?	◯ Yes ◯ No	Sensitivty to SWEETS?	◯ Yes ◯ No	Slowing healing sores in or around your	◯ Yes ◯ No
Avoid brushing partof your mouth due to	◯ Yes ◯ No	Gag easily?	◯ Yes ◯ No	Partials, dentures or any other removabl	◯ Yes ◯ No

If yes to any of the above please explain:

Question	Answer	
Have you had any other issue not listed above?	◯ Yes ◯ No	If yes
Have you ever had a blow/trauma to the jaw or	◯ Yes ◯ No	If yes
Are you unahppy with the appearance of your teeth?	◯ Yes ◯ No	If yes
Are you apprehensive or nervous about dental	◯ Yes ◯ No	If yes

TMJ

Do you have or have you had any of the following?

Pain in cheeks, jaw, temples, or in fron	◯ Yes ◯ No	Pain when chewing?	◯ Yes ◯ No	Pain when opening wide?	◯ Yes ◯ No
Noise in your jaw when opening or closin	◯ Yes ◯ No	Clenching or grinding of your jaws?	◯ Yes ◯ No	Jaws that feel tired or sore?	◯ Yes ◯ No
Limited mouth opening?	◯ Yes ◯ No	Mouth that will not open or close freely	◯ Yes ◯ No	Jaw pain that is more severe upon waking	◯ Yes ◯ No
Frequent headaches upon waking?	◯ Yes ◯ No	Been told you have TMJD	◯ Yes ◯ No	An appliance to wear at night?	◯ Yes ◯ No

Question	Answer	
Do you or have you taken medications or pills for pain or discomfort associated with your jaw?	◯ Yes ◯ No	If yes

Comments

Any other issues or concerns not addressed above?

Signature of Patient, Parent or Guardian:

X

Date:__________

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OUR INSURANCE AND FINANCIAL POLICY

____ I understand that Dr. Hara recommends treatment based on her professional judgment and consistent with current standards of the American Dental Association. She does not diagnose or recommend treatment based upon my insurance coverage.

____ I understand that if I have insurance, my dental insurance is a contract between me and the insurance company I also understand what is/isn’t covered is determined by the benefits that I or my employer purchased.

____Dr. Hara accepts all fee-for-service and PPO Insurance plans , however some plans may consider us “out of network” and reduce my benefit payment or amount available. We do not accept any HMO or Managed Care/Discount plans.

____I understand that my insurance will be billed as a courtesy and that **all balances not paid by the insurance company within 60 days are my responsibility** and must be paid within 15 days of statement date

(New Horizons Dental will cooperate with them in every way possible to help you obtain your maximum allowable benefit.)

____ I understand that benefits that are quoted to us either over the phone or online are only a brief overview of my plan and that it is only an estimate of coverage, it is **NEVER** a guarantee of payment.

____I agree to pay for any service at the time they are rendered

____ I understand larger treatment plans may require a non-refundable 10% deposit prior to scheduling. I will be notified of this at the time of scheduling.

____ Any appointment not cancelled within 24 hours of my appointment may be subject to a cancellation fee of $100. I understand that leaving a message after the office is closed for the day (or weekend before my appointment is NOT sufficient notice)

____ If I cancel my appointment more than twice for the same services, I may be required to place a deposit up to 50% prior to scheduling.

____New Horizons Dental does not “finance” treatment costs, however should I need “financing” Care Credit is available for those who qualify.

For your convenience, we accept the following methods of payment:
Cash, Personal Check, Visa, MasterCard, Discover, American Express and Care Credit.

Responsible Party Initial and Date:

X

___________________________________Date:___________

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I, ___________________________________ give my permission to share information concerning

- ○ My Dental Treatment
- ○ The cost and financial arrangements for my treatment
- ○ My Personal Health Information
- ○ Other ____

I give my permission to share the noted above information with:

○	_________________________________ Name	________________ Relationship
○	_________________________________ Name	________________ Relationship
○	_________________________________ Name	________________ Relationship
○	_________________________________ Name	________________ Relationship

This consent shall be in affect until :

- ○ **I terminate it**

or

- ○ **1 year from today's date**

____
Patient Name

____
Patient Signature

____
Date