Kshama Kheny, DDS - *Cosmetic and Family Dentistry*

Registration Form

Date: _____

Welcome! Thank you for trusting us with your dental care. Our goal is to help you reach and maintain maximum oral health. In order for us to best serve you, we ask that you please complete **ALL 4 pages** of this registration form. All patient information is kept confidential. Thank You! **(Please Print)**

Patient Information

Patient's Name (First, Last, MI):	Gender: [ ] Male [ ] Female	Date of Birth:	Marital Status:
Social Security #:	Driver's License # / State:	Home Phone:	
Cell Phone:	E-Mail Address:		
Address (not P.O. Box)	City:	State:	Zip:

Employment Information

Employer or School:	Title or Grade:	Work Phone:	
Employer or School Address:	City:	State:	Zip:

Responsible Party [ ] Same as above - Patient

Name:	Relation to patient:	Social Security #:	Driver's License # / State:
Home Phone:	Cell Phone:	Work Phone:	
Address (not P.O. Box) :	City:	State:	Zip:

Whom May We Thank For Referring You ?

[ ] Personal Referral:	[ ] PPO Insurance	[ ] Phonebook/Yellow Pages
[ ] Internet / Search Engine:	[ ] Direct Mail (Postcard)	[ ] Other:

Emergency Contact

Contact Name:	Phone Number:	Relationship:

Insurance Information

Primary Insurance (provide insurance card)			Secondary Insurance (if applicable)		
Name of Insured (First, Last, MI):	Date of Birth:		Name of Insured (First, Last, MI):	Date of Birth:	
Relationship to Patient: [ ] Self [ ] Spouse [ ] Parent [ ] Dependent	Gender: [ ] M [ ] F		Relationship to Patient: [ ] Self [ ] Spouse [ ] Parent [ ] Dependent	Gender: [ ] M [ ] F	
Subscriber ID or SSN:			Subscriber ID or SSN:		
Insurance Company:	Group Number:		Insurance Company:	Group Number:	
Insurance Phone Number:	Employee ID Number:		Insurance Phone Number:	Employee ID Number:	
Insurance Mailing Address (Street Address/P.O. Box):			Insurance Mailing Address (Street Address/P.O. Box):		
City:	State:	Zip:	City:	State:	Zip:

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Patient's Name: _____

Dental Health Information				
Name of Previous Dentist:	Phone Number:	City/State:	Date of last exam?	Date of last x-rays?
What is the reason for your visit with us today?			How often do you floss?	How often do you brush?

Has your physician told you that you require antibiotics before receiving dental treatment?
Are you currently in pain? If yes please describe:
Have you ever had a serious/difficult problem associated with any dental treatment? If yes please explain:
Do you or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?
Do you like your smile/teeth?

Please indicate if you have any of the following:

Bad Breath	**Y**	**N**	Grinding Teeth	**Y**	**N**	Sensitivity to Heat	**Y**	**N**
Bleeding Gums	**Y**	**N**	Jaw Clicking or Popping	**Y**	**N**	Sensitivity to Sweets	**Y**	**N**
Loose Teeth or Broken Fillings	**Y**	**N**	Red or White Patches in the Mouth	**Y**	**N**	Sensitivity When Biting	**Y**	**N**
Food Collection Between Teeth	**Y**	**N**	Sensitivity to Cold	**Y**	**N**	Sore or Growths in your Mouth	**Y**	**N**

Are you now or have you ever wanted to straighten your teeth with Braces or Invisalign?

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby consent my dentist to take any necessary X-rays, models, and photographs and perform a thorough diagnosis and treatment as needed. I also consent my dentist to perform all recommended treatment mutually agreed upon by us, and use of appropriate medication and therapy indicated for such treatment.

_____ _____

Signature of patient, parent or legal guardian ***Date***

_____

Dr. Kshama Kheny

Kshama Kheny, DDS - *Cosmetic and Family Dentistry*

Patient's Name: _____

Medical Health Information			
Name of Primary care Provider/Physician:	Phone Number:	City/State:	Date of Last Exam/Visit:

Please answer the questions below. If you answer yes to any of the following please specify.

Currently under the care of a physician?	**Y**	**N**	Family history of Cancer? If yes, specify:	**Y**	**N**
Smoke cigarettes and/or cigars? If yes, how often:	**Y**	**N**	Surgery or Radiation therapy for tumor, cancer, or other condition of the head and neck? If yes, specify:	**Y**	**N**
Do you drink alcohol or use recreational drugs? If yes, how often?	**Y**	**N**	Received or receiving bisphosphonate (Actonel, Boniva, Fosamax, Skelif, and Didronel) therapy? When?	**Y**	**N**
Have you had any or do you currently have any serious medical illness? If yes, specify:	**Y**	**N**	Taken any of the group of drugs collectively known as "Fen-Phen"? Include combinations of Lonimin, Adiipex, Fastin, Pondimin, or Redux.	**Y**	**N**
Hospitalized within the past 5 years? If yes specify:	**Y**	**N**	Currently taking aspirin, Warfarin, blood thinners, or anti-inflammatory drugs?	**Y**	**N**
Surgery/operation? If yes when and why:	**Y**	**N**	Abnormal bleeding with previous surgery, extractions, or trauma? Specify, How was it treated?	**Y**	**N**
Have you ever received a blood transfusion? If yes specify reason:	**Y**	**N**	Do you bruise easily?	**Y**	**N**
Women Only: Are you currently breastfeeding?	**Y**	**N**	Women only: Are you or is there a possibility you are pregnant?	**Y**	**N**

Do you have or have had any of the following medical conditions listed below?

AID/HIV positive	**Y**	**N**	Heart Disease / Murmur	**Y**	**N**	Mental or Nervous Disorder	**Y**	**N**
Arthritis or other Joint Problems	**Y**	**N**	Diabetes	**Y**	**N**	Fainting Spells/Seizures	**Y**	**N**
Artificial Joints or Heart Valves	**Y**	**N**	Kidney Disease	**Y**	**N**	Sinus Problems	**Y**	**N**
Blood disorders (Anemia, Hemophilia, Sickle Cell)	**Y**	**N**	Hepatitis, Jaundice, other Liver disease	**Y**	**N**	Allergies, Hives, Rash or Hay Fever	**Y**	**N**
High Blood Pressure	**Y**	**N**	Stomach problems / Ulcers	**Y**	**N**	Kidney or bladder disease	**Y**	**N**
Cancer? Specify:	**Y**	**N**	Sexually transmitted Disease(s)	**Y**	**N**	Asthma, Emphysema, other Lung Disease	**Y**	**N**
Cardiovascular (Heart)Disease(s)	**Y**	**N**	Glaucoma	**Y**	**N**	Persistent cough/coughing blood	**Y**	**N**
Tuberculosis	**Y**	**N**	Osteoporosis	**Y**	**N**	Other:		

Are you Allergic to or have you ever had a reaction to any of the following? (If yes, please specify what happened)

Dental Anesthetics	**Y**	**N**	Tetracycline	**Y**	**N**	Erythromycin	**Y**	**N**	Aspirin	**Y**	**N**
Latex	**Y**	**N**	Penicillin	**Y**	**N**	Codeine other Narcotics	**Y**	**N**	Sulfa Drugs	**Y**	**N**

Other:

Please list ALL Medications you are currently taking:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have change in health. Should further information be needed, you have my permission to request my health care provider to release the information to you.

_____ _____ _____

Signature of patient, parent or legal guardian ***Date*** ***Dr. Kshama Kheny***

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CONSENT FOR SERVICES & OFFICE POLICIES

Financial and Insurance Policies:

It is our objective to provide our patients with the latest dental technology, superior dental materials and excellent care in a modern comfortable environment. I hereby give my approval and consent to start my dental treatment and assume complete financial responsibility for all services rendered. As a courtesy to our patients, we will file your dental insurance claims and bill your dental insurance company for treatments you receive. I understand that personal payments and/or insurance deductable & copayments are due at the time of service unless other prior arrangements have been made.

Please take the time to read and understand your insurance policy and benefits. In most cases, dental insurance is a contract between you and your dental insurance company. The benefits you receive are based on the terms of the contract that were negotiated between you and your dental insurance company, and not our dental office. Our goal is to help you achieve and maintain optimal dental care. Our office will do everything possible to help you understand and make the most of your dental insurance benefits. To the best of my knowledge, I am currently eligible for dental treatment through my insurance company. I also understand that, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you.

Any account balance which is not on the payment plan and which is over 60 days old will have finance charges of 1.5% per month (18% APR) added. In the event that an account becomes past due over 90 days, it may be given to an outside collection agency, unless previously written financial arrangements have been agreed. As per our office policy, release of dental records (including digital XRays) will require a signed release form and is subject to a $25 fee.

Appointment Cancellation Policy:

We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved for you. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 48 hours notice if you need to reschedule your appointment. We reserve the right to charge patients who do not reschedule their appointments with adequate notice, or who fail to keep their scheduled appointments, an appropriate cancellation fee of $50/per hour applies for broken appointment.

I have read the above conditions of payment and agree to their content.

_____ _____ _____

Patient's Name ***Signature of patient, parent or legal guardian*** ***Date***

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) took effect on April 14, 2003. This federal law requires our office to provide a notice of privacy practices. You may also request a paper copy. We appreciate you acknowledging having received our "Notice of Privacy Practices" with an effective date of 9-23-2013. This notice is also posed in the office and you may request another copy at any time.

_____

Signature for acknowledgement of receipt of NOTICE OF PRIVACY PRACTICES

Proposition 65:

The state of California, under proposition 65, now requires every dentist to give each of their patients a copy of the information relating to materials and techniques used in the dental environment. This information is contained in the attached document entitled "DENTALMATERIALS FACT SHEET". It is required that all patients sign they have received a copy of this document. We would appreciate you taking the time to sign the bottom of this form certifying you have received a copy of the DENTAL MATERIALS FACT SHEET. If you have any questions regarding information contained within the document please feel free to bring your questions to our attention.

_____

Signature for receipt of DENTAL MATERIALS FACT SHEET