MARCH DENTAL CARE

Patient Registration

Today's Date _____

☐ Mr.
☐ Mrs.
☐ Dr.
☐ Ms. _____ Name you like to be called _____

How you found us _____

Address _____ City _____ Zip _____

Home Phone (_____)_____ Home FAX (_____)_____

Work Phone (_____)_____ Cell Phone (_____)_____

Date of Birth _____ Age _____ E-mail _____

Employer Name _____ SSN _____

Occupation _____ Length of Employment _____

Business Address _____

City _____ Zip_____

Name of Spouse/Partner_____ Occupation _____

Employed by _____ Length of Employment _____

YOUR PHYSICIAN: _____ PREVIOUS DENTIST: _____

Address _____ Address_____

Phone (_____)_____ Phone (_____)_____

PERSON TO CONTACT IN AN EMERGENCY:

Name_____ Relationship_____

Home Address_____

Primary Phone (_____)_____ Secondary Phone (_____)_____

PARTY RESPONSIBLE FOR PAYMENT OF ACCOUNT _____

Address _____City _____State_____ Zip_____

Primary Phone (_____)_____ Secondary Phone (_____)_____

IF YOU HAVE DENTAL INSURANCE, PLEASE FILL OUT THE DENTAL INSURANCE INFORMATION FORM. THANK YOU.

MARCH DENTAL CARE

Dental Insurance Information

Insured's Name _____

Insured's Birth Date_____ Insured's ID or Social Security Number_____

Patient's ID or Social Security Number_____

Insured's Employer _____

Insurance Company_____Group No._____Local No._____

Insurance Co. Address & Phone No.:_____

_____

Do you have dual insurance coverage? Yes No If yes, please complete:

Insured's Name _____

Insured's Birth Date_____ Insured's ID or Social Security Number_____

Insured's Employer _____

Insurance Company_____Group No._____Local No._____

Insurance Co. Address & Phone Number_____

_____

Authorization for Release of Health Information & Signature On File

I authorize March Dental Care to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits. I further authorize Dr. Ravneet K. Nijjar, DMD to affix my name to any and all claims or documents as related to any and all health benefits due me through my employment with _____.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

I know that I have the right to receive a copy of this authorization if requested.

_____
Name of Patient

_____ _____
Date Signature of Patient, Parent or Guardian

PATIENT NAME (Please print): _____

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question):

1. ☐ Yes ☐ No Are you in pain or discomfort at this time?
2. ☐ Yes ☐ No Do you feel nervous about having dental treatment?
3. ☐ Yes ☐ No Have you had problems with prior dental treatment or have you had a bad dental experience?
4. ☐ Yes ☐ No Is your general health good?
5. ☐ Yes ☐ No Has there been a change in your health within the last year?
6. ☐ Yes ☐ No Have you been hospitalized or had a serious illness in the last three years? If YES, why? _____
7. ☐ Yes ☐ No Are you being treated by a physician now? For what? _____

Date of last medical exam:_____ Date of last dental exam: _____

II. DO YOU HAVE OR HAVE YOU HAD:

8. ☐ Yes ☐ No Allergies to: drugs, medications, latex, foods?
9. ☐ Yes ☐ No Cardiac transplant that developed a heart valve problem?
10. ☐ Yes ☐ No A history of infective endocarditis?
11. ☐ Yes ☐ No An artificial heart valve?
12. ☐ Yes ☐ No Cyanotic congenital heart disease (unrepaired or incompletely repaired)?
13. ☐ Yes ☐ No Congenital heart defect completely repaired with a prosthetic material or device?
14. ☐ Yes ☐ No Repaired congenital heart defect with a residual defect at the site or adjacent to the site of a prosthetic patch or device?
15. ☐ Yes ☐ No Any joint replacement surgery?
16. ☐ Yes ☐ No A joint replacement less than 2 years ago?
17. ☐ Yes ☐ No Previous prosthetic joint infections?
18. ☐ Yes ☐ No Rheumatoid arthritis or systemic lupus erythematosus?
19. ☐ Yes ☐ No Insulin dependent diabetes?
20. ☐ Yes ☐ No HIV infection/AIDS?
21. ☐ Yes ☐ No Drug- or radiation-induced immunosupression?
22. ☐ Yes ☐ No Hemophilia?
23. ☐ Yes ☐ No An implanted coronary artery bare-metal stent? Date placed:_____
24. ☐ Yes ☐ No An implanted coronary artery drug-eluting stent? (DES)? Date placed:_____

III. DO YOU TAKE OR HAVE YOU EVER TAKEN?

25. ☐ Yes ☐ No Drugs for osteoporosis (e.g. Fosamax, Actonel, Boniva)?
26. ☐ Yes ☐ No Chemotherapy IV drugs: Aredia (pamidronate), Bonefos (clodronate), Zometa (zolendronic acid)?
27. ☐ Yes ☐ No Anti-platelet therapy (e.g. Aspirin + Plavix (clopidogrel) or Ticlid (ticlopidine)?
28. ☐ Yes ☐ No The diet pills FEN-PHEN or REDUX?
28a. ☐ Yes ☐ No Since taking the drug, have you been evaluated by a cardiologist and had an echocardiogram?
28b. ☐ Yes ☐ No IF YES, has a cardiologist diagnosed heart damage and recommended antibiotic prophylaxis for dental care?

IV. HAVE YOU EXPERIENCED:

29. ☐ Yes ☐ No Chest pain (angina pectoris)?
30. ☐ Yes ☐ No Swollen ankles?
31. ☐ Yes ☐ No Shortness of breath?
32. ☐ Yes ☐ No Recent weight loss, fever, night sweats?
33. ☐ Yes ☐ No Persistent cough, coughing up blood
34. ☐ Yes ☐ No Bleeding problems, bruising easily, hemophilia?
35. ☐ Yes ☐ No Sinus problems?
36. ☐ Yes ☐ No Difficulty swallowing?
37. ☐ Yes ☐ No Diarrhea, constipation, blood in stools?
38. ☐ Yes ☐ No Frequent vomiting, nausea?
39. ☐ Yes ☐ No Difficulty urinating, blood in urine?
40. ☐ Yes ☐ No Dizziness?
41. ☐ Yes ☐ No Ringing in ears?
42. ☐ Yes ☐ No Headaches?
43. ☐ Yes ☐ No Fainting spells?
44. ☐ Yes ☐ No Blurred vision?
45. ☐ Yes ☐ No Seizures or epilepsy?
46. ☐ Yes ☐ No Excessive thirst?
47. ☐ Yes ☐ No Frequent urination?
48. ☐ Yes ☐ No Dry mouth?
49. ☐ Yes ☐ No Jaundice?
50. ☐ Yes ☐ No Joint pain, stiffness?

Continued on next page

PATIENT NAME (Please print): _____

V. DO YOU HAVE OR HAVE YOU HAD:

51.	☐ Yes	☐ No	Heart disease, heart failure?	60.	☐ Yes	☐ No	Tumors, cancer?
52.	☐ Yes	☐ No	Heart surgery	61.	☐ Yes	☐ No	Arthritis, osteoarthritis?
53.	☐ Yes	☐ No	Heart attack, heart defects?	62.	☐ Yes	☐ No	Eye diseases, glaucoma?
54.	☐ Yes	☐ No	Stroke, hardening of arteries?	63.	☐ Yes	☐ No	Skin diseases?
55.	☐ Yes	☐ No	High blood pressure?	64.	☐ Yes	☐ No	Anemia?
56.	☐ Yes	☐ No	Asthma, TB, emphysema, other lung diseases?	65.	☐ Yes	☐ No	VD (syphilis or gonorrhea)?
57.	☐ Yes	☐ No	Hepatitis, other liver disease?	66.	☐ Yes	☐ No	Herpes, cold sores?
58.	☐ Yes	☐ No	Stomach problems, ulcers, colitis?	67.	☐ Yes	☐ No	Kidney, bladder disease?
59.	☐ Yes	☐ No	Family history of diabetes, heart problems, tumors?	68.	☐ Yes	☐ No	Thyroid, adrenal disease?
				69.	☐ Yes	☐ No	Diabetes?

VI. DO YOU HAVE OR HAVE YOU HAD:

70.	☐ Yes	☐ No	Psychiatric care?	75.	☐ Yes	☐ No	Blood transfusions?
71.	☐ Yes	☐ No	Drug addiction?	76.	☐ Yes	☐ No	Surgeries (including cosmetic surgeries)?
72.	☐ Yes	☐ No	Radiation treatments?	77.	☐ Yes	☐ No	Heart pacemaker?
73.	☐ Yes	☐ No	Chemotherapy?	78.	☐ Yes	☐ No	Contact lenses?
74.	☐ Yes	☐ No	Hospitalization?				

VII. DO YOU USE OR DO YOU TAKE:

79.	☐ Yes	☐ No	Recreational drugs?	81.	☐ Yes	☐ No	Tobacco in any form?
80.	☐ Yes	☐ No	Drugs, medications, over-the-counter medicines (including aspirin), natural remedies?	82.	☐ Yes	☐ No	Alcohol?
				83.	☐ Yes	☐ No	Do you take or have you taken cortisone medication (steroids)?

Please list drugs and medications that you are currently taking:

List the Allergies:

VIII. WOMEN ONLY:

84.	☐ Yes	☐ No	Are you or could you be pregnant or nursing?	85.	☐ Yes	☐ No	Taking birth control pills?

IX. ALL PATIENTS:

86. ☐ Yes ☐ No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ **Date:** _____

UPDATE REVIEWS:

Patient's signature: _____ **Date:** _____

Patient's signature: _____ **Date:** _____

Patient's signature: _____ **Date:** _____

Patient's signature: _____ **Date:** _____

Patient's signature: _____ **Date:** _____

MARCH DENTAL CARE

GENERAL DENTISTRY INFORMED CONSENT FORM

1. EXAMINATION AND X-RAYS: I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. CHANGES IN TREATMENT PLAN: I understand that, during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination—the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions to the treatment plan as necessary.

3. DRUGS, MEDICATION, AND SEDATION: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand this and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of any anesthetic medication or drugs that may be given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

4. FILLINGS: I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

5. CROWNS, BRIDGES, VENEERS AND BONDING: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. I understand that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

6. DENTURES – COMPLETE OR PARTIAL: I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

7. ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal treatment will save a tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

8. PERIODONTAL TREATMENT: I understand that serious periodontal conditions causing gum inflammation and/or bone loss can lead to the loss of my teeth. I understand that treatment plans (non-surgical cleaning, gum surgery and/or extractions) may vary depending on the severity of periodontal conditions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

9. REMOVAL OF TEETH (EXTRACTION): I understand that if a tooth is not savable by e.g. root canal therapy, crowns, periodontal surgery, etc., it may be recommended that the tooth be extracted. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand that the following are some risks involved in having teeth removed: pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

10. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ): I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

CONSENT: I have read and understood the above information. Further, I understand that dentistry is not an exact science; therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance as been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.

X SIGNATURE: _____ X DATE: _____

Financial Information

Thank you for choosing ***March Dental Care.*** Our mission is to deliver the best and most comprehensive care to our entire patient family. We wish to make the cost of such great dental care easy and manageable. Please read our **Financial Policy** and acknowledge your understanding by signing below.

Payment Options: Due at the time service is rendered

You may choose from:

-Cash, Check ($30 charge for returned checks), Visa, MasterCard, American Express, or Discover Card.

-We accept FSA.

-Convenient Third Party Financing from Care Credit that offers the flexibility of deferred interest and extended monthly payments, a small application is required.

-We offer pre-payment discount for treatment paid in full, cash or check 5%, or with credit card 2.5%.

Treatment Reservation:

At ***March Dental Care*** we make every effort to stay on time, accommodate the needs of our entire patient family, and fit in unexpected emergencies. To respect the time of all our patients and providers, a **non-refundable** payment equaling 25% of the treatment estimate might be required to hold time especially for the patient. The payment is due upon reserving the time, and will be **applied** to the total **treatment** estimate. If the patient does not show or cancels with **less than 48 hours' notice**, a cancellation fee of $75 will be applied.

No Show/Late Policy

We manage the needs of our entire patient family. As a courtesy to each other, and the providers, please give us as much notice as possible if you need to change your appointment. Should a patient cancel or reschedule with **less than 24 hours' notice**, and does so **more than twice**, we will require a **reservation deposit** to hold future appointments. The deposit will be held on the account and can be applied to treatment, however will be **forfeited** if **insufficient notice** is given for appointment changes. Additionally, if you are **15 minutes late**, we may have to **reschedule** you to avoid making your provider late for their next appointment.

Insurance Claims:

Your insurance policy is an agreement between you and your insurance company. We are happy to submit claims and necessary documentation to see that you receive the full benefits of your coverage. However, we cannot guarantee any estimated coverage. Ultimately, the patient is responsible for the full cost of treatment regardless of your insurance company's determination of coverage or acceptable fees. It is the patient's responsibility to know the details of policy benefits, and ***March Dental Care*** cannot guarantee the accuracy of information obtained from the insurance company, nor is ***March Dental Care*** responsible for your insurance coverage or payments.

Patients Without Insurance Coverage:

We offer a 5% courtesy for advanced payment in full for treatment. To take advantage of this courtesy, payment must be made in full at least one week prior to the date treatment is scheduled by cash or check.

If you have any questions, please do not hesitate to ask a member of our staff for clarification regarding any of the policy.

Signature: _____ *Date:* _____

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I acknowledge that I have received from Dr. Ravneet Nijjar, the Dental Materials fact Sheet that was updated on September 21, 2020

Patient Name

Signature of Patient, Parent, or Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of the Notice of Privacy Practices from Dr Ravneet Nijjar.

Patient Name

Signature of Patient, Parent, or Guardian Date