Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

E-mail _____ Alt. Phone #1 (_____) _____ Alt. Phone #2 (_____) _____

Employer/School _____ Employer/School Phone (_____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (_____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (_____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (_____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (_____) _____

Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (_____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

– OVER –

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DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Congenital Heart Lesions	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Cortisone Treatments	☐	☐	Hernia Repair	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Skin Rash
☐	☐	Artificial Joints, Pins, etc.	☐	☐	Cough up Blood	☐	☐	HIV/AIDS	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Swelling of Feet or Ankles
☐	☐	Back Problems	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Thyroid Problems
☐	☐	Bleeding Abnormally	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Tobacco Habit
☐	☐	Blood Disease	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Cancer	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Ulcer
☐	☐	Chemotherapy	☐	☐	Heart Problems	☐	☐	Respiratory Disease	☐	☐	Venereal Disease
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Rheumatic Fever			

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies:

_____

_____

_____

AUTHORIZATION AND RELEASE

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 a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

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

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

Payment is due in full at time of treatment unless prior arrangements have been approved.

Hariram R. Kabra, D.D.S.

PONDVIEW MEDICAL ARTS BUILDING
2500 PONDVIEW ROAD
CASTLETON, NEW YORK 12033-0201
TELEPHONE (518) 477-7537

WELCOME TO PONDVIEW FAMILY DENTAL SRVCS, DR. HARIRAM KABRA

WE APPRECIATE YOUR TRUST IN US AND LOOK FORWARD TO BUILDING A RELATIONSHIP WITH YOU AND YOUR FAMILY MEMBERS

As a courtesy to Dr. Kabra, our staff, and other patients, please comply with our Office Policies:

This office is under no obligation to remind you of your appointments; however, we will make confirmation calls 2-3 days ahead of time as a courtesy to you.

Please give our office 48 hour notice if you cannot keep your appointment. A fee of $25.00 will be charged to you if you don't show up or call. Your insurance will not cover this charge.

Arriving on time is critical to our office as patients are scheduled before and after you. It is the Doctor's discretion to reschedule your appointment if you are late.

We expect you to pay your co-pay, deductible, co-insurance and any back balances due at the time of your appointment. We accept all major credit cards, checks, cash and offer Care Credit (payment plan)

If you or anyone in your family misses three unexplained visits over a 12 month period, you will be dismissed from this office.

Please sign below that you have read and understand our policies. Thank you.

_____/DATE_____

Hariram R. Kabra D.D.S
Pond View Family Dental Services, P.C.
2500 Pond View RD, STE 201
Castleton, NY 12033
(518) 477-7537

Patient HIPAA Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information.

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers Who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your Notice Of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice Of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice Of Privacy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice Of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient:_____ Date:_____