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## PATIENT INFORMATION:

Full Name:

Preferred Name:  Gender:

Email Address:


Date of Birth:  SS#:

Address:

City:

State:  Zip Code:

Phone Number (✓preferred):  Work:   Cell:

Social Networking \*optional: 

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## INSURANCE INFORMATION:

Patient is:  Responsible Party  Policy Holder

Have you used this insurance before ?  YES  NO

Primary Insurance:  Policy #:

Employer:

Relationship to Policy Holder:

Details for Policy Holder If not self:

Full Name:

Date of Birth:  SS#:

Secondary Insurance:  Policy #:

Employer:

Relationship to Policy Holder:

Details for Policy Holder If not self:

Full Name:

Date of Birth:  SS#:



# DENTAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Referred by \_\_\_\_\_ How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor

Previous Dentist \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_ Months/Years

Date of most recent dental exam \_\_\_/\_\_\_/\_\_\_ Date of most recent x-rays \_\_\_/\_\_\_/\_\_\_

Date of most recent treatment (other than a cleaning) \_\_\_/\_\_\_/\_\_\_

I routinely see my dentist every  3 mo.  4 mo.  6 mo.  12 mo.  Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_

## PLEASE ANSWER YES OR NO TO THE FOLLOWING:

### PERSONAL HISTORY



YES NO

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [\_\_\_\_] \_\_\_\_\_  YES  NO
2. Have you had an unfavorable dental experience? \_\_\_\_\_  YES  NO
3. Have you ever had complications from past dental treatment? \_\_\_\_\_  YES  NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_  YES  NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? \_\_\_\_\_  YES  NO
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? \_\_\_\_\_  YES  NO

### GUM AND BONE



YES NO

7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? \_\_\_\_\_  YES  NO
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? \_\_\_\_\_  YES  NO
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? \_\_\_\_\_  YES  NO
10. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_  YES  NO
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? \_\_\_\_\_  YES  NO
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? \_\_\_\_\_  YES  NO
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? \_\_\_\_\_  YES  NO

### TOOTH STRUCTURE



YES NO

14. Have you had any cavities within the past 3 years? \_\_\_\_\_  YES  NO
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? \_\_\_\_\_  YES  NO
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_  YES  NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? \_\_\_\_\_  YES  NO
18. Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_  YES  NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_  YES  NO
20. Do you frequently get food caught between any teeth? \_\_\_\_\_  YES  NO

### BITE AND JAW JOINT



YES NO

21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking? \_\_\_\_\_  YES  NO
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together? \_\_\_\_\_  YES  NO
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_  YES  NO
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? \_\_\_\_\_  YES  NO
25. Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_  YES  NO
26. Are your teeth developing spaces or becoming more loose? \_\_\_\_\_  YES  NO
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? \_\_\_\_\_  YES  NO
28. Do you place your tongue between your teeth or close your teeth against your tongue? \_\_\_\_\_  YES  NO
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_  YES  NO
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore? \_\_\_\_\_  YES  NO
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? \_\_\_\_\_  YES  NO
32. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_  YES  NO

### SMILE CHARACTERISTICS



YES NO

33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)? \_\_\_\_\_  YES  NO
34. Have you ever bleached (whitened) your teeth? \_\_\_\_\_  YES  NO
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? \_\_\_\_\_  YES  NO
36. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_  YES  NO

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_



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## CANCELLATION POLICY

We understand that unexpected situations arise, and we appreciate your courtesy in notifying us as soon as possible if you need to reschedule. This allows us to accommodate other patients in need of care.

- Please provide at least 24 hours' notice for appointments one hour or less.
- For appointments longer than one hour, we require 48 hours' notice.

Late Cancellations & No-Shows:

Failure to provide the required notice will result in a \$150 cancellation fee.

Frequent Cancellations & Rescheduling Conflicts:

Patients with recurring scheduling issues may be placed on our ASAP list, meaning they will only be offered appointments as openings become available.

By signing below, you acknowledge and agree to this policy.

Thank you for your cooperation in respecting our time and the care we provide to all our patients.

Full Name:

Date:

Signature:

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## INFORMED CONSENT

I understand that as a patient of Kumar Dental Studio, I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that all information shared with the clinicians here are confidential and no information will be released without my consent. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at the Kumar Dental Studio. I may discuss them with her. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Nina Kumar, DDS. I understand that I may stop treatment at any time.

Full Name:

Date:

Signature:

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# NOTICE OF PRIVACY PRACTICE

**PURPOSE:** This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. (Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.) We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after November 17, 2009. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

**OUR LEGAL DUTY:** We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/10/2009, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION:** We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. Required by Law: We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health 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 disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

## PATIENT RIGHTS:

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$150 for each page, \$20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

**Questions & Complaints:** If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.



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## Patient Acknowledgement of NOTICE OF PRIVACY PRACTICE

I have received and understand this Practice's Notice of Privacy Practices written in plain language. This notice provides in details the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information. This practice reserves the right to change the terms of its Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Full Name:

Date:

Signature: