KINGS DENTAL GROUP

5 WEST D STREET, LEMOORE, CA 93245

NANDITA PANCHAL, D.D.S.
559.924.2206

Welcome. *The information on these forms will enable us to provide the best care possible for you. This information is confidential. The thoroughness of this medical history is designed for your safety, and your complete answers will assist us in treating you with every consideration for your special needs.*

PATIENT INFORMATION

Name_____ ❒ Dr. ❒ Mr. ❒ Mrs. ❒ Ms. ❒ Miss.
First MI Last

I prefer to be called_____ Birth Date _____/_____/_____ SS #:_____

Home address_____ City_____ Zip_____

List the numbers you permit us to contact you at.

Home Ph # _____ Work Ph # _____ Cell Phone # _____

E-mail address_____

Your occupation_____ Employer_____

Business address_____ City_____ Zip_____

Spouse's name_____ Occupation_____ Work Ph #:_____

We like to thank those who referred you to our office.

How did you hear about our practice?_____

Other than your spouse, a person to contact in case of emergency: Name_____

Relation to patient_____ Home Ph #:_____ Work Ph #:_____

I give consent to share information with ☐ spouse, ☐ parents, or other_____

FOR OUR PATIENTS WITH DENTAL INSURANCE . . .

Name of policy holder _____ Birth date ___/___/___ SS#: _____

Insurance Co._____ Group #:_____

Name of employer_____ Relation to patient_____

Are you covered by another insurance plan?

Name of policy holder _____ Birth date ___/___/___ SS#: _____

Insurance Co._____ Group #:_____

Name of employer_____ Relation to patient_____

DENTAL HISTORY

Tooth or Oral Symptoms		Past Dental Treatment	
Hot or cold sensitivity?	Y N	Orthodontic treatment?	Y N
Biting or chewing difficulty?	Y N	Oral surgery?	Y N
Have you noticed mouth odors or bad tastes?	Y N	Periodontal treatment? Or "Deep Cleaning"	Y N
Cold sores, blisters or any other oral lesions?	Y N	A mouth guard or night guard?	Y N
Do your gums bleed or hurt?	Y N	Your bite adjusted?	Y N
Food caught routinely between your teeth?	Y N	Antibiotic Premedication?	Y N
Clicking or popping of the jaw?	Y N	Oral Sedation?	Y N
Pain in the joint, ear, or side of face?	Y N	A less than positive dental experience?	Y N
Dry mouth?	Y N	Used OTC whitening agents, like White Strips	Y N
		Anti-viral medication for cold sores?	Y N

Do you:		Oral Hygiene Habits
Clench or grind your teeth while awake or asleep?	Y N	How often do you brush your teeth each day?
Smoke or chew tobacco?	Y N	
Drink 2 or more sweetened drinks per day	Y N	How often do you floss?
Bite your lips or cheeks regularly?	Y N	
Mouth breathe while awake or asleep?	Y N	What other dental aides do you use? (circle or write) Powered brush water pik toothpicks
Have tired jaws, especially in the morning?	Y N	
Have difficulty in opening or closing your mouth?	Y N	What toothpaste do you use?
Have headaches or neck pain?	Y N	
How frequently?		What other OTC dental adjuncts do you use? (circle or write) Fluoride Xylimints Kanka Antibacterial
Have a high chance of dozing while watching TV?	Y N	
Use a denture adhesive?	Y N	

Related Dental Topics

Is keeping your own teeth an important goal for you?	Y N
Do you feel nervous about having dental treatment?	Y N
Is there anything about your smile that you would like to change?	Y N
Have your parents experienced gum disease or tooth loss?	Y N
Are you concerned about the long-term health of your teeth?	Y N
If you could easily and safely whiten your teeth, would you be interested?	Y N
Is maintaining dental health more important to you than insurance coverage?	Y N
Is it important for you to understand the reasons for treatment recommendations?	Y N
Would you like to prevent or decrease the chances of future dental emergencies?	Y N
Would you like us to keep track of your treatment progress to ensure that it is completed?	Y N
Is there anything else we need to know about you to help you feel more comfortable?	
What are you looking for in a dental office?	
I would be interested in using your Bose noise-reducing headphones during dental treatment.	Y N

MEDICAL HISTORY

Name of personal physician_____ Phone #:_____

How do you assess your current health: ❒ Excellent ❒ Good ❒Fair ❒ Poor

Are you currently under the care of a physician? ❒ Yes ❒ No
If yes, please explain:_____

Have you been hospitalized or had any serious medical problems within the past 5 years? ❒ Yes ❒ No
If yes, please explain:_____

Do you have heart problems or any form of cardiovascular disease?

Yes	No		Yes	No	
❒	❒	Angina (chest pains) Frequency_____	❒	❒	Heart Surgery (date)_____
❒	❒	Heart attack (date) _____	❒	❒	Pacemaker
❒	❒	High blood pressure	❒	❒	Stroke (date)_____
❒	❒	Heart Valve issues			
❒	❒	Other Cardiac issues_____			

Have you ever had or been treated for any of the following diseases or medical problems?

Yes	No		Yes	No	
❒	❒	Hepatitis/Jaundice	❒	❒	Taking Bisphosphonates ❒ IV? ❒ SQ?
❒	❒	Abnormal bleeding or bruising	❒	❒	Last bone density test _____
❒	❒	Liver disease/Cirrhosis	❒	❒	Weight Loss Surgery
❒	❒	Epilepsy/Seizures/Fainting	❒	❒	Kidney problems
❒	❒	Cancer/Chemotherapy	❒	❒	Diabetes
❒	❒	Psychiatric problems/disabilities	❒	❒	Asthma or lung disease
❒	❒	Tuberculosis	❒	❒	Hip or joint replacement
❒	❒	HIV+	❒	❒	Anemia
❒	❒	Drug/Alcohol abuse	❒	❒	Arthritis
❒	❒	Gastric/Intestinal Ulcers	❒	❒	Glaucoma
❒	❒	Sleep Apnea	❒	❒	Acid Reflux/ GERD
❒	❒	Skin Disease (Lupus, SJ, ELP)	❒	❒	Eating disorder
❒	❒	Radiation treatment	❒	❒	HA/HB/HC
❒	❒	Osteoporosis/Osteopenia			

Have you been treated for any other illnesses not listed above? ❒ Yes ❒ No If yes, please explain:

_____

Are you allergic to any of the following medications?

Yes	No		Yes	No		Yes	No	
❒	❒	Penicillin	❒	❒	Dental Anesthetic	❒	❒	Nickel
❒	❒	Erythromycin	❒	❒	Aspirin	❒	❒	Other _____
❒	❒	Codeine	❒	❒	Latex			

Have you ever been advised to take antibiotics before dental treatment? ❒ Yes ❒ No

Are you currently taking prescription medications or dietary supplements? ❒ Yes ❒ No (If yes, please list below)

Name of Medication	Purpose	Name of Medication	Purpose

Do you use "Recreational" drugs ❒ Yes ❒ No

"Recreational" drugs such as cocaine, marijuana, stimulants or depressants (prescription and over-the-counter) may have dangerous interactions with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

Women: Are you pregnant? ❒ Yes ❒ No If so, expected delivery date_____

Women: Are you taking birth control pills? ❒Yes ❒ No

Certain antibiotics may adversely interact with oral contraceptives.

Is there any issue or condition that you would like to discuss with the dentist in private? ❒ Yes ❒ No

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the doctor and office team. I also give permission for the doctor or his team to use any photos he may take to be used for lecturing or educational purposes. I understand that I am financially responsible for all treatment rendered, regardless of insurance involvement. I also give permission for Dr and team to call me or text me on my cell phone concerning my account payments and insurance information, I also understand that I can withdrawal from text or calls anytime. I, acknowledge at my request I may receive a copy of the Dental Materials Fact Sheet and Notice of Privacy Practices.

I give consent to share information regarding my dental needs with spouse or other _____

_____ _____

Signature of Patient or Guardian (if patient is a minor) Date

Health Questionnaire reviewed by _____ _____ _____

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INFORMATION REGARDING OUR PRACTICE

PHILOSOPHY. The goal of our practice is to provide exceptional dental treatment keeping with the latest technologies and standards. Furthermore, it is our goal to treat you with the utmost of care and concern for your comfort, well-being, and understanding. We are here to serve you. We set aside time in our work schedule—several times every day—to see you on an urgent basis should a need arise. Also, we will gladly discuss any questions you may have concerning financial matters. If you become aware of some aspect of our care that falls short of your expectations, please do not hesitate to inform us. We are approachable and welcome any feedback.

APPOINTMENTS. We recognize the value of your time. Therefore, we will do our best to seat you as promptly as possible. Likewise, it is important that you come to your appointment on time so we can treat you and our following patients in a timely manner. Also, if you have a time urgency and must have treatment completed by a given time, please inform us upon your arrival and we will do our best to accommodate you.

CANCELLATIONS AND BROKEN APPOINTMENTS. When we schedule an appointment, that time is reserved for you. We will do our best to help you remember, but if you simply don't show up, we have lost the opportunity to serve another patient in need. So, if you must reschedule an appointment, please call the office during business hours *at least 48 working-hours in advance. We will bill a nominal fee of $70.00 for any appointment that you cancel in less than 24 hours or simply do not keep.* If you fail three (3) appointments we reserve the right to discontinue our relationship with you and your records will be forwarded to another doctor at your request.

Initial

DENTAL INSURANCE. This office desires to provide a high level of service and quality of care. Because of this, we are not able to contract with some insurance programs. And we will recommend procedures that your insurance company may not cover. Because the insurance policy is an agreement between you and the insurance company, and is often chosen by your employer for you, *we would remind you that you are inevitably responsible for all charges. It behooves you to familiarize yourself with your insurance benefits.* Yet, we will work with your insurance company and file the forms necessary to see that you receive the full benefits of your coverage; however, *we cannot guarantee any estimated coverage*. Your insurance claims that have not been paid after 60 days will become your responsibility. Yet, we will do everything possible to ensure you receive the maximum benefits you deserve.

Initial

PAYMENT OPTIONS. In our on-going commitment to keep our fees as reasonable as possible, we ask all of our patients to be prepared to take care of their charges at the time of service, if not, before. For patients who desire a monthly payment plan, our office offers two convenient options with Care Credit. Approval is provided quickly, and there are no application fees or pre-payment penalties. *We may also ask you to reserve certain restorative appointments with the payment of the expected patient portion for that service one week in advance of expected treatment.* Accounts that become 30 days overdue are subject to a 1.5% monthly service charge. Returned checks due to insufficient funds will incur an additional $25.00 fee.

_____ _____

Patient Signature Date