Prava Dental · Purvi Pandya, DDS · 10300 Louetta Rd., Ste 132 · Houston, TX 77070

HEALTH HISTORY FORM

Name: ____ Date of Birth: ____/___/_____

DENTAL HISTORY

What is the reason for your dental visit today? ____

Former dentist ______________________________ Date of last dental visit ____________ Date of last dental x-rays __________

	Yes	No		Yes	No
Do gums bleed when brush/flossing?	☐	☐	Are teeth sensitive to hot,cold,sweets,pressure?	☐	☐
Is your mouth dry?	☐	☐	Have you had any periodontal (gum) txtmt?	☐	☐
Have you had any orthodontic txtmt?	☐	☐	Is your jaw popping, clicking, or painful?	☐	☐
Do you brux or grind your teeth?	☐	☐	Do you have any earaches or neck pains?	☐	☐
Date of last dental exam: ___________			Are you currently experiencing any dental pain or discomfort?	☐	☐

MEDICAL HISTORY

Physician's Name: ____________________________________ Phone: ________________________________

Please list any illnesses or conditions you are currently being treated for? ____

Please list all prescription, natural, and/or over the counter medications being taken? __________________________________

____

Allergy to Penicillin, local anesthetics, Latex, Codeine or Other Drugs? ☐Yes ☐No Specify: __________________________________

Have you had orthopedic total joint (hip, knee, elbow, finger) replacement? **Yes / No / DK** If yes, Date: _______________

Are you taking or scheduled to take alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's Disease? **Yes / No / DK**

Since 2001, were you treated or scheduled to be treated with IV bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? **Yes / No / DK**

WOMEN: Are you pregnant? ☐ Yes ☐ No Due date: ____________ Nursing? ☐Yes ☐ No Taking birth control pills? ☐Yes ☐ No

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Artificial/prosthetic heart valve	☐	☐	☐	Cardiovascular disease	☐	☐	☐	Gastrointestinal dis.	☐	☐	☐
Previous infective endocarditis	☐	☐	☐	Angina (chest pain)	☐	☐	☐	G.E. reflux/heartburn	☐	☐	☐
Heart transplant	☐	☐	☐	Arteriosclerosis	☐	☐	☐	Ulcers	☐	☐	☐
Congenital heart disease	☐	☐	☐	Congestive heart failure	☐	☐	☐	Thyroid problems	☐	☐	☐
Mitral valve prolapse	☐	☐	☐	Damaged heart valves	☐	☐	☐	Stroke	☐	☐	☐
Pacemaker	☐	☐	☐	Heart attack	☐	☐	☐	Glaucoma	☐	☐	☐
Rheumatic fever	☐	☐	☐	Heart murmur	☐	☐	☐	Hepatitis, jaundice,			
Rheumatic heart disease	☐	☐	☐	Low blood pressure	☐	☐	☐	or liver disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐	High blood pressure	☐	☐	☐	Epilepsy	☐	☐	☐
Anemia	☐	☐	☐	Other congenital heart				Fainting or seizures	☐	☐	☐
Blood transfusion	☐	☐	☐	defects	☐	☐	☐	Neurological disorders	☐	☐	☐
If yes, date:___________				Hemophilia	☐	☐	☐	If yes, specify:________________			
AIDS or HIV infection	☐	☐	☐	Arthritis	☐	☐	☐	Mental health disorders	☐	☐	☐
Autoimmune disease	☐	☐	☐	Rheumatoid arthritis	☐	☐	☐	If yes, specify: _______________			
Systemic lupus	☐	☐	☐	Asthma	☐	☐	☐	Sexually transmitted			
Cancer/Chemotherapy/				Bronchitis	☐	☐	☐	disease	☐	☐	☐
Radiation treatment	☐	☐	☐	Emphysema	☐	☐	☐	Kidney problems	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐	Sinus trouble	☐	☐	☐	Osteoporosis	☐	☐	☐
Severe headaches/migraines	☐	☐	☐	Diabetes Type I or II	☐	☐	☐	Tuberculosis	☐	☐	☐
Use controlled substances (drugs)	☐	☐	☐	Tobacco use	☐	☐	☐	Alcoholic beverages	☐	☐	☐
If yes, specify:_____________				If yes, specify:___________________				If yes, how often/wk: __________			

Do you have any condition not listed above you think I should know about? Explain. ____

I certify that I have read and understand the above and that the information on this form is accurate. I understand the importance of a truthful health history and that my dentist and her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Guardian:____ Date:_____________________

PRAVA DENTAL - Purvi T. Pandya, D.D.S.

10300 Louetta Rd., Suite 132   Houston, TX 77070   281.251.7770

PATIENT INFORMATION (Please print)

Date: __/__/___

Name _______________________________ Preferred Name____________ Birthdate __/__/____

SSN _____-_____-_____ DL # & State ___________ Sex: M__ F__ Marital Status: ________

Address_____________________________ City________________ State_____ Zip_____________

Home Phone _________________ Work Phone_________________ Cell Phone_________________

E-mail Address ___________________________ Best time to call_______________

Emergency Contact Name_____________________________ Phone Number__________________

How did you hear about Prava Dental/Dr. P. Pandya?_______________________________

RESPONSIBLE PARTY (If different from above)

Name____________________________ Relationship___________________ Birthdate __/__/____

SSN____-____-_____ DL # & State___________________ Sex: M__ F___ Marital Status:_______

Address_________________________________ City__________________ State____ Zip_________

Home Phone_______________ Work Phone_______________ Cell Phone_____________________

DENTAL INSURANCE INFORMATION

Name of Insured____ Birthdate ___/____/_______

SSN _____-_____-_______ Name of Employer ____

Insurance Co.________________________ Group #_______________ Phone#________________

CONSENT

I authorize payment directly to dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this I attest to the accuracy of the information on this page.

Patient or Guardian Signature____________________________________ Date____/____/_______

PRAVA DENTAL
Purvi T. Pandya, D.D.S.
10300 Louetta Rd., Suite 132
Houston, TX 77070
(281) 251-7770

Financial Policy Disclaimer

We are pleased you have chosen Prava Dental for your dental needs. Our Financial Policy is based on an open and honest discussion of our fees. Please read and sign the following:

Insurance

You, as the patient, are responsible for all charges regardless of insurance coverage. As a courtesy to our patients, we will file your dental insurance for you. We will, to the best of our ability, provide the insurance company with all the necessary radiographs and narratives to get your insurance claim paid. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. If the claim is denied or paid only partially by the insurance company, then the patient is responsible for payment and balance. You as the insured have the right to appeal, but at that point when we have exhausted all our means, we cannot get involved and the balance must be paid in full by the patient.

Payments

As a courtesy to our patients, we accept MasterCard, Visa, Discover, American Express, and checks with proper identification. There will be a $25.00 charge on all returned checks, and the balance must then be paid in full whether it is cash or money order. If the balance remains unpaid, we will not see the patient until the balance has been cleared. Patients with an outstanding balance of 30 days or more overdue must make arrangements for payments prior to scheduling appointments.

If treatment needs to be performed and your total cost has been explained to you, we do expect payment at the time treatment is rendered. By your cost, we mean your percentage of the “estimated” cost for treatment per your insurance company (co-insurance, deductible, and/or co-payment). Please keep in mind that when we call for verification of benefits, nothing is guaranteed. It is only an estimate until the insurance companies review the claim.

We appreciate you keeping your account with us in good standing. After 60 days any balances remaining on your account will accrue a 10% interest monthly. At 90 days we send our outstanding accounts to collections and your account will have an additional 30% interest applied to cover our costs from the collection agency. If you have any questions on your account at any time be sure to speak with our office manager.

Missed Appointment/Late Cancellations

Your appointment time is set aside for you. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time reserved for you. Please call our office at least 24 hours prior to your appointment if you must cancel or reschedule. Unfortunately, if the required notice is not given, a fee of $45.00 will be charged and immediately payable. Excessive abuse of this policy may result in discharge from the practice. We do realize that emergencies do occur and will take this into consideration on a patient-to-patient basis.

I have read and understand the *Prava Dental* financial policy. I agree to assign insurance benefits to *Prava Dental & Dr. Purvi Pandya* when necessary. I also agree that should it become necessary to forward my account for collection proceedings, in addition to the amount owed, I will also be responsible for the fees associated with the costs of collection.

____ ____________

Responsible Party Signature Date

I wish to include the following family members in this agreement:

____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Giving Consent:

Name:____

Address: ____

Telephone: __________________________________

Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice is available with this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Purvi T. Pandya, D.D.S.
10300 Louetta Rd., Suite 132
Houston, TX 77070

Phone: (281) 251-7770
Fax: (281) 251-7708

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature:____ Date:__________________

If a personal representative on behalf of the patient signs this consent, complete the following.

Personal Representative's Name:____

Relationship to Patient:____

Revocation of Consent
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:____ Date:______________________