Dr. Rachna Ranjan D.M.D.
136 Parliament Loop Ste. 1000
Lake Mary, FL 32746
Phone #: (407) 324 - 4420 Fax #: (407) 289-5239

PATIENT REGISTRATION

First Name: ____________ **Last Name:** ____________ **Middle Initial:** ______

Preferred Name: ____________

Address: ______________________ Home#: (____) ______-______

City/State/Zip code ______________________ Work #: (____) ______-______

Marital Status: ○*Single* ○*Married* ○*Divorced* ○*Separate* ○*Widowed* Cell #: (____) ______-______

Gender: ○*Male* ○*Female* Birth Date: ____/____/______ SS#: ____-____-______

E-mail: ______________________ *I would like to receive correspondences via e-mail:* ○*Yes* ○*No*

RESPONSIBLE PARTY (*If someone other than the patient*)

First Name: ____________ Last Name: ____________ Middle Initial: ______

Address: ______________________ Home#: (____) ______-______

______________________ Work #: (____) ______-______

Marital Status: ○*Single* ○*Married* ○*Divorced* ○*Separate* ○*Widowed* Cell #: (____) ______-______

Gender: ○*Male* ○*Female* Birth Date: ____/____/______ SS#: ____-____-______

E-mail: ______________________ *I would like to receive correspondences via e-mail:* ○*Yes* ○*No*

EMERGENCY CONTACT *Relationship:* ____________

First Name: ____________ Last Name: ____________

Phone#: (____) ______-______ Additional#: (____) ______-______

HOW YOU WERE REFERRED TO US

Family/Friend: ________ Website: ________ Phone Book: ________ Other: ________

PRIMARY DENTAL INSURANCE INFORMATION

Name of the Insured: First____________ Last ____________

Relation to Insured: ○*Self* ○*Spouse* ○*Child* *Other*________

Employer: ________ Insured Birth Date: ____/____/______ Insured SS#: ____-____-______

Insurance Company: ____________ Insurance Phone #: (____) ______-______

SIGNATURE of Patient, Parent or Guardian: ______________________ **Date:** ____/____/______

******(FOR FUTURE VISITS) Have There Been Any Changes With Address, Phone #(s), and/or Insurance?***

○ *No* *If YES:* ______________________ *Initial:* ________ *Date:* ____/____/______

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○ *No* *If YES:* ______________________ *Initial:* ________ *Date:* ____/____/______

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MEDICAL HISTORY

Patient's Name: ______________________________ ***Date:*** ____/____/______

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ YES ◯ NO ***IF yes**, please explain* ____________
Have you been hospitalized or had a major operation? ◯ YES ◯ NO ***IF yes**, please explain* ____________
Have you ever had a serious head/back/neck injury? ◯ YES ◯ NO ***IF yes**, please explain* ____________
Are you taking any medications, pills, or drugs? ◯ YES ◯ NO ***IF yes**, please explain* ____________
Do you take/have you taken Phen-Fen or Redux? ◯ YES ◯ NO ____________
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ◯ YES ◯ NO ____________
Do you use tobacco? ◯ YES ◯ NO

WOMEN: *Are you…* ***(Men: do not fill this part)***
Pregnant/ Trying to get pregnant? ◯ Yes ◯ No   Taking oral contraceptives? ◯ Yes ◯ No   Nursing? ◯ Yes ◯ No

ALLERGIES *to any of the following?*
◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Local anesthetics ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa drugs
◯ **NONE** ◯ ***IF OTHER**, please explain* ____________

DO YOU HAVE, OR HAVE YOU HAD, *any of the following?* **(Draw a line through "NO" if most are "NO" and circle "YES")**

Condition	Y	N	Condition	Y	N	Condition	Y	N	Condition	Y	N
AIDS/HIV +	__Y	__N	Cortisone Medicine	__Y	__N	Hemophilia	__Y	__N	Radiation Treatments	__Y	__N
Alzheimer's Disease	__Y	__N	Diabetes	__Y	__N	Hepatitis A	__Y	__N	Recent Weight Loss	__Y	__N
Anaphylaxis	__Y	__N	Drug Addiction	__Y	__N	Hepatitis B or C	__Y	__N	Renal Dialysis	__Y	__N
Anemia	__Y	__N	Easily Winded	__Y	__N	Herpes	__Y	__N	Rheumatic Fever	__Y	__N
Angina	__Y	__N	Emphysema	__Y	__N	High Blood Pressure	__Y	__N	Rheumatism	__Y	__N
Arthritis/Gout	__Y	__N	Epilepsy/Seizures	__Y	__N	High Cholesterol	__Y	__N	Scarlet Fever	__Y	__N
Artificial Heart Valve	__Y	__N	Excessive Bleeding	__Y	__N	Hives/Rash	__Y	__N	Shingles	__Y	__N
Artificial Joint	__Y	__N	Excessive Thirst	__Y	__N	Hypoglycemia	__Y	__N	Sickle Cell Disease	__Y	__N
Asthma	__Y	__N	Fainting Spells/Dizziness	__Y	__N	Irregular Heartbeat	__Y	__N	Sinus Trouble	__Y	__N
Blood Disease	__Y	__N	Frequent Cough	__Y	__N	Kidney Problems	__Y	__N	Spina Bifida	__Y	__N
Blood Transfusion	__Y	__N	Frequent Diarrhea	__Y	__N	Leukemia	__Y	__N	Stomach/Intestinal Disease	__Y	__N
Breathing Problem	__Y	__N	Frequent Headaches	__Y	__N	Liver Disease	__Y	__N	Stroke	__Y	__N
Bruise Easily	__Y	__N	Genital Herpes	__Y	__N	Low Blood Pressure	__Y	__N	Swelling of Limbs	__Y	__N
Cancer	__Y	__N	Glaucoma	__Y	__N	Lung Disease	__Y	__N	Thyroid Disease	__Y	__N
Chemotherapy	__Y	__N	Hay Fever	__Y	__N	Mitral Valve Prolapse	__Y	__N	Tonsillitis	__Y	__N
Chest Pains	__Y	__N	Heart Attack/Failure	__Y	__N	Osteoporosis	__Y	__N	Tuberculosis	__Y	__N
Cold Sores/ Fever Blisters	__Y	__N	Heart Murmur	__Y	__N	Pain in Jaw Joints	__Y	__N	Tumors/Growths	__Y	__N
Congenital Heart Disorder	__Y	__N	Heart Pacemaker	__Y	__N	Parathyroid Disease	__Y	__N	Ulcers	__Y	__N
Convulsions	__Y	__N	Heart Trouble/Disease	__Y	__N	Psychiatric Care	__Y	__N	Venereal Disease	__Y	__N
									Yellow Jaundice	__Y	__N

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ____________

Comments: ____________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE of Patient, Parent or Guardian: ____________ **Date:** ____/____/______

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NOTICE TO OFFICE POLICIES:
PPO, TRADITIONAL AND COMMERCIAL INSURANCE PATIENTS

Patient's Name: ______________________________ ***Date:*** ____/____/______

- Our practice is dedicated to quality care and service. **We respect the importance of our patient's time and work very hard to schedule appointments which are accommodated into the busy scheduling needs of all our patients.** In return, we ask patients to arrive on time and make every effort not to change reserved dental appointments because it may create scheduling problems for our patients as well as the practice. We realize emergencies occur, but we ask for your assistance in this regard. If you find you must cancel an appointment, **we require a minimum of 48 hours notice,** so we may accommodate another patient. If a patient does not **CALL** to cancel and/or fails to show as scheduled, there may be a charge of **$25.00 fee per appointment reserved for that day.**

- If there have been any insurance changes it is very important our office is notified. **At the time dental services are rendered, full payment is expected upon receipt of the statement.** If treatment is started and not completed within the necessary time, F.D.C. has the right to adjust the balance on a patient(s)'s account and charge for required services such as additional lab fees.

- **The patient is responsible for:** *co-pay, co-insurance, deductible and any non-covered services*. As a courtesy, we submit claims for completed dental treatments to your dental insurance company. Therefore, we are not responsible for how your insurance company handles the claim(s) or for what benefits they choose to pay on any claim. If for any reason your insurance company determines our diagnoses and treatment do not meet the criteria of your contract, they may deny payment to this practice. We will work with you to appeal any such finding by your insurance company resulting in denial. We make every attempt to file claims accurately and to resolve errors if they occur. You are responsible for understanding your coverage as well as clauses, etc. pertaining to your dental treatment. **We will estimate what your own out of pocket estimate will be, however, please understand this is ONLY an estimate and you will be responsible for all expenses the insurance does not pay. We do not have a contract with your insurance company, only you do.** *Fees quoted for treatment are honored for 12 months from the time given (unless your insurance/our fees change).*

- If a patient is unable to make a payment in full, contact our office to discuss payment options. We work with Care Credit, a low interest financing company which allows patients to finance (with approved credit) the cost of their dental treatment. If an account is sent to collections, the patient will be charged a collection- handling fee of 35% of the balance transferred to the collection agency.

- If for any reason a patient decides to leave our practice, we can provide duplicates and/or copies of dental records and/or x-rays after a record release form has been signed (as required by law) and a **$15.00 process fee** has been collected.

We accept cash and most credit/debit cards such as:
Visa, Master Card, Discover, American Express
WE DO NOT ACCEPT CHECKS.
Thank you for your cooperation in this matter.
I have read (or had read to me) and understand this form:

SIGNATURE of Patient, Parent or Guardian ______________________________

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Patient's Name: ______________________________ ***Date:*** ____/____/______

My signature confirms I have been informed of my rights to privacy regarding my protected health information under the *Health Insurance Portability & Accountability Act of 1996 (I-IIPA)*. I understand this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in any treatment directly and indirectly.
- Obtain payment from third-payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy containing a more complete description of the uses and disclosure of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand my dental provider has the right to change the Notice of Privacy Practices.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations; I also understand you, Dr. Rachna Ranjan, are not required to agree to my requested restrictions, but if you agree, then you (Dr. Rachna Ranjan) are bound to abide by such restrictions

List any dependent family members (including spouse) authorizing Dr. Rachna Ranjan and staff to discuss **ANY/ALL** of treatment(s) - including fees and finances with the following person(s):

____

____

____

SIGNATURE of Patient, Parent or Guardian: ______________________________ **Date:** ____/____/______