# 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 ______________________ Home Phone (____) ______________________

Address ______________________ City ______________________ State ________ Zip ________

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

☐ Separated ☐ Divorced ☐ Partnered for ______ years

E-mail ______________________ Cell Phone #1 (____) ______________________ Cell 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 ____________

– O V E R –



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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 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

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

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

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.***

# Super Smile Center

**7115 Leesburg Pike Suite # 216**
**Falls Church, VA 22043**
**Office Number (703) 532-4400**

**About your Payment:**
I understand that I am financially responsible for all charges. Payment is expected as services are rendered. We accept Cash, Visa, MasterCard, Discover and American Express.

**About your Insurance:**
We will be happy to help you with any insurance questions. We will also help you receive the maximum benefits available under your policy.

Please remember that YOU ARE RESPONSIBLE FOR PAYMENT. Remember too, that no insurance will cover ALL dental costs. It is your responsibility to pay any deductible, co-insurance or other balances not paid for by your insurance company. This will be noted on your monthly statements. Let us know if there are any problems you are aware of with your claim status so that we can help you to resolve it as soon as possible. (Some insurance companies are just slow payers)

Please be sure we have all the correct information (name and address of company, SSN # of employee, etc) or your claim may be delayed or rejected due to error or omission. It is very important that you provide us with all required insurance information.

Your insurance is an agreement between you and the insurance company only. We prepare and send your insurance claims as a service to our patients. We try to make insurance as simple and convenient for you as possible in this way.

Thank you,

Dr. Amisha N. Shroff, D.D.S.

________________________________
SIGNATURE

# Super Smile Center

**7115 Leesburg Pike Suite # 216**
**Falls Church, VA 22043**
**Office Number (703) 532-4400**

Dear Patient,

Every effort is made to keep on schedule so we respectfully ask patients to be prompt in keeping their appointment. Our standard office policy regarding appointments is as follows:

We try to remind patients by telephone and email prior to the appointment but, please DO NOT depend on this courtesy. If we are unable to contact you, your appointment email will serve as the confirmation of your appointment and implies your obligation to be present. That time has been reserved especially for you. If you need to change your appointment, please try to give us at least 24 hours notice so we can avoid lost appointment time.

<u>NO CALL-NO SHOW POLICY:</u>

Our office has a NO-CALL NO SHOW POLICY that we do enforce. If you have incurred three NO-CALL NO SHOWS then our office will no longer see you as a patient. Our time, like yours, is valuable so if you find that you cannot keep a scheduled appointment, please have the courtesy to call us and cancel.

If you have any questions or wish to inform us of some problem of which we may not have been aware of please call.

Thank you for your future cooperation's!

Dr. Amisha N. Shroff, D.D.S

____________________________

SIGNATURE

# HIPAA PRIVACY FORM 2

## SUPER SMILE CENTER

## ACKNOWDLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**YOU MAY REFUSE TO SIGN THIS ACKNOWLEGDGEMENT**

PURPOSE: THIS FORM IS USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICE TO DOCUMENT OUR GOOD FAITH EFFORT TO ONTAIN THAT ACKNOWLEDGEMENT.

____________________, have received a copy of this office's Notice of Privacy Practices.

______________________

PLEASE PRINT NAME

______________________

SIGNATURE

______________________

DATE

For Office Use Only

Attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice. Our acknowledgement could not be obtained because:

_________________Individual refused to sign

_________________Communications barriers prohibited obtaining the acknowledgement

_________________An emergency situation prevented us from obtaining the acknowledgment

_________________Other (Please specify)