COSMETIC DENTAL CENTER OF FORT BEND

RISHI KHANNA, DMD, PC

Date: _____

Name: _____ DOB:_____

Address: _____

City_____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Insurance Company _____

ID #:_____ SSN: _____

Group #:_____ Phone #: _____

Policy Holder _____ DOB: _____

Policy Holder Employer: _____

Relationship to Policy Holder (please circle): SELF SPOUSE CHILD OTHER

Emergency Contact: _____ Phone #: _____

How did you hear about us? _____

Time 12:12 PM

Rishi Khanna DMD, PC
DR. RISHI KHANNA, DMD

Date 3/27/2017

Patient Name:

Birth Date:

Date Created:

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 medication

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you taking any blood thinners?	Yes No	If yes
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

☐ Trying to get pregnant?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other allergies?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
Yellow Jaundice Yes No			

Have you ever had any serious illness not listed	Yes No	If yes

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:

X

Date:_____

COSMETIC DENTAL CENTER OF FORT BEND

4645 SWEETWATER BLVD, SUITE 300
SUGAR LAND TX 77479

FINANCIAL / APPOINTMENT POLICY

Our goal is to provide you with the best possible dental care for your wants and needs. All fees are disclosed to you before treatment is performed. Payment is due at the time services are rendered. We accept cash, checks, Visa/MasterCard, American Express and Discover. We can help you arrange financing through Care Credit. There is a $25.00 fee for any returned check. If you have dental insurance we will be happy to file your insurance claims for reimbursement and thus help you to receive your maximum allowable benefits. **Please note: Your insurance is a contract between you and your insurance company.**

If you have insurance please inform the office prior to being treated. This will allow plenty of time to get benefit information. Your insurance provider can also answer your questions you may have regarding coverage. While the filing of claims is a courtesy we extend to our patients, all fees are your responsibility from the date services are rendered. If for any reason your insurance provider decides to deny benefits it will be your responsibility to pay for the outstanding balance. We allow 45 days from the date of submission for reimbursement. If payment is not received with in the stated time frame a statement will be sent directly to you for payment. All estimated co-pays are due at the time services are rendered.

We strive to make sure all scheduled patients are seen on a timely basis. All appointments are scheduled exclusively to fit your individual needs. Out of respect for our office and other patients, it is requested you give advance notice of cancellation. We reserve the right to charge for appointments cancelled or broken without 24 hours' notice. Our fee is $35.00 per hour of scheduled time. Please keep in mind a broken appointment could have been utilized by another patient in need of care.

Also, please be aware that if you are 30 minutes late or more to your appointment we reserve the right to reschedule your appointment and apply a late cancellation fee.

Signature _____ Date_____

NOTICE OF PRIVACY PRACTICES

DR. RISHI KHANNA, D.M.D.
4645 SWEETWATER BLVD., SUITE 300
PHONE: 281-313-5888
FAX: 281-313-5898

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

ACKNOWLEGE OF RECEIPT:

I acknowledge that I have read and/or received a copy of Dr. Rishi Khanna's Notice of Privacy Practices.

Print Patient Name: _____

Signature: _____

Date: _____