NAME (First) _____ (Middle) _____ (Last) _____

DATE OF BIRTH _____ Age _____ ☐ M ☐ F Social Security # _____

☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower **EMAIL** _____

PHONE (Mobile) _____ (Home) _____ (Work) _____

HOME ADDRESS _____

City _____ State _____ Zip Code _____

WORK ADDRESS _____

EMERGENCY CONTACT _____ Phone _____

REFERRING DENTIST _____ Phone _____

MEDICAL DOCTOR _____ Phone _____

PHARMACY (Name) _____ Phone _____

Pharmacy Address _____

HOW WILL YOU PAY? ☐ Cash ☐ Credit Card ☐ Insurance

MANISHA GOSWAMI, DMD

MEDICAL HISTORY

Patient Name _____

Please circle any that apply

HIGH BLOOD PRESSURE	ASTHMA	TUBERCULOSIS
PROSTHETIC VALVE	DIABETES	HEPATITIS
ANY OTHER HEART SURGERY	EPILEPSY	HIV/ AIDS
CONGENITAL HEART LESION	STROKE	ULCERS
HEART MURMUR	BLOOD DISEASE	JOINT REPLACEMENT
PACEMAKER	ANEMIA	
RHEUMATIC HEART DISEASE	JAUNDICE	

Drug Allergies

(Drugs that you cannot take)

☐ NO KNOWN DRUG ALLERGIES ☐ ASPIRIN, ☐ CODEINE, ☐ PENICILLIN
☐ LOCAL ANESTHETIC (MEDICINES SIMILAR TO NOVOCAINE)

☐ OTHERS _____

1.	Have you been a patient in a hospital during past 2 years?	YES	NO
2.	Have you been under the care of a physician during the past 2 years?	YES	NO
3.	Are you taking any kind of medicine or drugs routinely?	YES	NO
4.	Have you ever had any excessive bleeding requiring special treatment?	YES	NO
5.	Have you ever had any other serious illness?	YES	NO
6.	Are you pregnant now?	YES	NO
7.	Is this treatment necessary as the result of an accident?	YES	NO
8.	Have you been treated for Hepatitis, HIV exposure?	YES	NO

If you answered YES to any question, please explain

_____

_____

CARDHOLDER PRE-AUTHORIZATION OF PAYMENT AGREEMENT

I, _____ hereby give my permission to settle my account for any outstanding balance due with the following credit card, or care credit account information:

VISA MASTERCARD AMEX DISCOVER CARE CREDIT

CREDIT CARD# _____

EXP. DATE _____ CODE _____

PAYMENT TO BE APPLIED ON (DATE): _____

SIGNATURE _____ DATE _____

PRINT NAME _____

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

☐ Statement of Actual Services **– OR –** ☐ Request for Predetermination / Preauthorization

☐ EPSDT / Title XIX

2. Predetermination / Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number	10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other	39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining	43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) / 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box)

☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID	50. License Number	51. SSN or TIN

52. Phone Number ( ) –

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) Date

54. Provider ID	55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) –	58. Treating Provider Specialty

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that 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 are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

√ Patient signature _____ Date _____