

# Billerica Dental Associates

Dr. A.G. Khan

## WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

### PATIENT INFORMATION

Date \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_ M \_\_\_ F Age \_\_\_\_\_ Birth Date \_\_\_\_\_

\_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated

Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone # (\_\_\_\_) \_\_\_\_\_

Cell Phone # (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of Emergency, who should be notified? \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

### PRIMARY INSURANCE

**All of the following must be completed so that Billerica Dental Associates can process insurance payments properly**

Person responsible for account \_\_\_\_\_  
Last Name First Name

Relationship to patient \_\_\_\_\_ Birth Date \_\_\_\_\_

Soc Sec # \_\_\_\_\_

Person responsible employed by \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone # (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of the other dependents covered under the plan \_\_\_\_\_

\_\_\_\_\_

**DENTAL HISTORY**

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Last date of dental care \_\_\_\_\_ Date of last dental X-Rays \_\_\_\_\_

Check (X) if you have had problems with any of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding Teeth                 |
| <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Loose Teeth or Broken Fillings |
| <input type="checkbox"/> Clicking or Popping Jaw       | <input type="checkbox"/> Periodontal Treatment          |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Sensitivity to Cold            |
| <input type="checkbox"/> Sensitivity to Hot            | <input type="checkbox"/> Sensitivity to Sweets          |
| <input type="checkbox"/> Sensitivity to Biting         | <input type="checkbox"/> Sores or Growth in Your Mouth  |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Aids                   | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Scarlet Fever       |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arthritis, Rheumatism  | <input type="checkbox"/> Heart Problems Headaches | <input type="checkbox"/> Skin Rash           |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Swelling of Ankles  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Swelling of Feet    |
| <input type="checkbox"/> Back Problems          | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Tobacco Habit       |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Jaw Pain                 | <input type="checkbox"/> Tonsillitis         |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Circulatory Problems   | <input type="checkbox"/> Nervous Problems         |  |
| <input type="checkbox"/> Cortisone Treatments   | <input type="checkbox"/> Pacemaker                |  |
| <input type="checkbox"/> Cough, Persistent      | <input type="checkbox"/> Psychiatric Care         |  |
| <input type="checkbox"/> Cough up Blood         | <input type="checkbox"/> Radiation Treatment      |  |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Respiratory Disease      |  |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Rheumatic Fever          |  |
| <input type="checkbox"/> Fainting               |   |  |
| <input type="checkbox"/> Heart Problems         |   |  |

Describe \_\_\_\_\_

List Current Medications

Allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION**

I authorize my insurance company to pay to the dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment due in full at time of treatment unless prior arrangements have been approved**

# Billerica Dental Associates

## OFFICE POLICIES

It is our goal to provide you with the finest quality dental care. If you have any questions with regard to your dental care or any of our policies, please let us know. We welcome your referrals and look forward to a pleasant doctor-patient relationship based on communication and trust.

## APPOINTMENT POLICY

We endeavor to honor your valuable time and understand emergencies that may arise. We would like to make you aware that we will see you for emergencies which may delay other appointments. We also want to explain that the doctors' and hygienists' time is also valuable, and have scheduled appointments for your convenience. For this reason we expect you to be on time for your appointment. Broken appointments may be subject to a charge. We may refuse to schedule appointments if you have consistently broken appointments. A minimum of 24 hours notice to cancel is required.

## FINANCIAL POLICY

### PRIVATE

1. Payment for services is due at the time services are rendered unless the treatment requires more than one visit to complete. The balance for those treatments, such as a root canal, may be split over the number of visits that it takes to complete the treatment.
2. We accept cash, checks, Mastercard, VISA, or ask about our special credit card charge; a payment plan specifically for dental use.

### INSURANCE

1. We will be happy to file your insurance claim for you. While this is a courtesy that we extend to our patients, the charges are your ultimate responsibility.
2. Deductibles and co-payments are due at the time of the visit if they apply.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Some insurance companies require their own form. If you do not submit a form, you will be responsible for the balance that day.
5. We must emphasize that as dental care providers, our relationship is with you, not the insurance company. The contract is between you, your employer, and the insurance company. We are not a party to that contract.

If you have any questions about the above information, please do not hesitate to ask.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Billerica Dental Associates

Dr. A.G. Khan, D.M.D.  
8 Tower Farm Road  
Billerica, MA 01821  
(978) 667-8292

## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 at the address below 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 to 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

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## CONSENT TO CONFIRM APPOINTMENTS

May we send post cards and confirm appointments on your answering machine?

\_\_\_\_\_Yes    \_\_\_\_\_No

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_