MANATEE ORAL & FACIAL SURGERY CENTER

PRASHANT PANDYA, D.M.D.

BOARD CERTIFIED ORAL SURGEON

New Patient Registration

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Rev ☐ Ms. ☐ Miss ☐ Dr.	Print Full Legal Name: Last	First	Middle
☐ Female ☐ Male	Date of Birth: (Month/Day/Year)	Social Security Number:	Preferred Name:
Mailing Address:	Apt #	PO Box #	
City:	State:	Zip Code:	Email:
Home Phone # (with area code)	Work Phone # (with area code)	Cellular/Other Phone # (with area code)	
Alternate/Permanent Address: *(if different than above)*	City:	State:	Zip Code:

EMERGENCY CONTACT INFORMATION

Emergency Contact:	Last Name:	First Name:	Middle Name:
Relationship:	Home Phone # (with area code)	Other Phone # (with area code)	

RESPONSIBLE PARTY INFORMATION

Print Full Legal Name:	Relationship to Patient:	Social Security Number:	
Mailing Address:	Apt #	PO Box #	
City:	State:	Zip Code:	Email:

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Carrier:	Policy Holder Name:	Policy Holder Birthdate:	Insurance ID:	Employer Name:

PATIENT DEMOGRAPHICS

The following information is collected to better track the demographics of our patient population

Ethnicity: ☐ White/Caucasian ☐ Asian ☐ Hispanic ☐ Black/African American ☐ Other _____	Language Preference: ☐ English ☐ Spanish ☐ Other _____
How did you hear about us? ☐ College of Dentistry Patient ☐ Friend ☐ Family ☐ Internet ☐ Phone Book ☐ Other _____ ☐ Referring Dr. _____	

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Patient's Name: _____ Patient's Date of Birth: _____

Medical History Form

Are you under a physician's care now? ◯ Yes ◯ No

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? **Please provide a list if available.** ◯ Yes ◯ If yes, please explain: _____

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 on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women Are you:

Pregnant/trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you **ALLERGIC** to any of the following?

☐ ASPIRIN ☐ PENICILLIN ☐ CODIENE ☐ LOCAL ANESTHETIC ☐ ACRYLIC ☐ METAL ☐ LATEX ☐SULFA DRUGS ☐ OTHER _____

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

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatment	◯ 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/Genital 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 Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Yellow Jaundice	◯ 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

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

Comments:_____

_____

_____

Physician Information

Physician: (if applicable)	Specialty:	Phone:

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: _____

MANATEE ORAL & FACIAL
SURGERY CENTER
PRASHANT PANDYA, D.M.D.
BOARD CERTIFIED ORAL SURGEON

Patient's Name: _____ Patient's Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

By signing this form, you grant use and disclose of your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

I, _____, have read the contents of this consent form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health information to carry out treatment, payment activities, and health care operations.

_____
Print Patient's Name

_____
Patient's Signature

_____
Date

Our Privacy Officers can be contacted as follows:

Address:	5460 Lena Rd Ste.102	4016 9th Ave West
	Bradenton, FL 34211	Bradenton, FL 34205
Phone Number: (941)755-6637		(941)792-8900

Authorization to Release Information

This form is used to obtain to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
Please Print Name Relationship

_____ _____
Please Print Name Relationship

MANATEE ORAL & FACIAL SURGERY CENTER

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BOARD CERTIFIED ORAL SURGEON

Patient's Name:_____ Patient's Date of Birth:_____

Financial Policy Consent Form

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you **read, agree to, and** sign prior to any treatment. By making our policies clear we hope to avoid any problems or misunderstandings.

Please note that payment of your bill is considered part of your treatment. **Payment is due at the time services are rendered.** Our office accepts cash, personal checks, MasterCard, Visa, American Express, Discover and Care Credit. Outside financing with Care Credit is available upon request and approval. Care Credit transactions will only be processed with purchases of $300 or more. We offer a 3% discount for all treatment over $2000 paid in CASH.

[ ] Please check if you would like more information about financing options.

Returned checks will be subject to additional fees. Checks that are returned to our office from your financial institution are subject to a $75.00 returned check fee. This fee covers the processing fees that are charged to our office.

Do You Have Insurance?
As a courtesy to you we will help you process your dental insurance claims. Please understand that we will provide an insurance estimate to you, however **it is not a guarantee** that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. **Our office is not a party to that contract.**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We ask that you sign this form and/or any other necessary document that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

We ask that you pay the deductible and co-payment, and the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Amex, Discover or Care Credit at the time we provide the service to you.

Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter a dispute with your insurance company over any claim.

Deposit/Rescheduling Policy:
Due to extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for reservations over 45 minutes, we require a deposit of half of the treatment fee to make your reservation.
If proper notice is not received, a fee of $50.00 will be charged to the patient for every hour of allotted time. For larger cases that special items may have been ordered a larger cancellation fee may occur. Implant cases will have a cancellation/restocking fee of $300.00.

We thank you for the opportunity to serve your dental health needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

Signed:	**Date:**
[ ]Patient [ ]Parent [ ]Legal Guardian [ ]Responsible Party	

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BOARD CERTIFIED ORAL SURGEON

INTRODUCING: _____

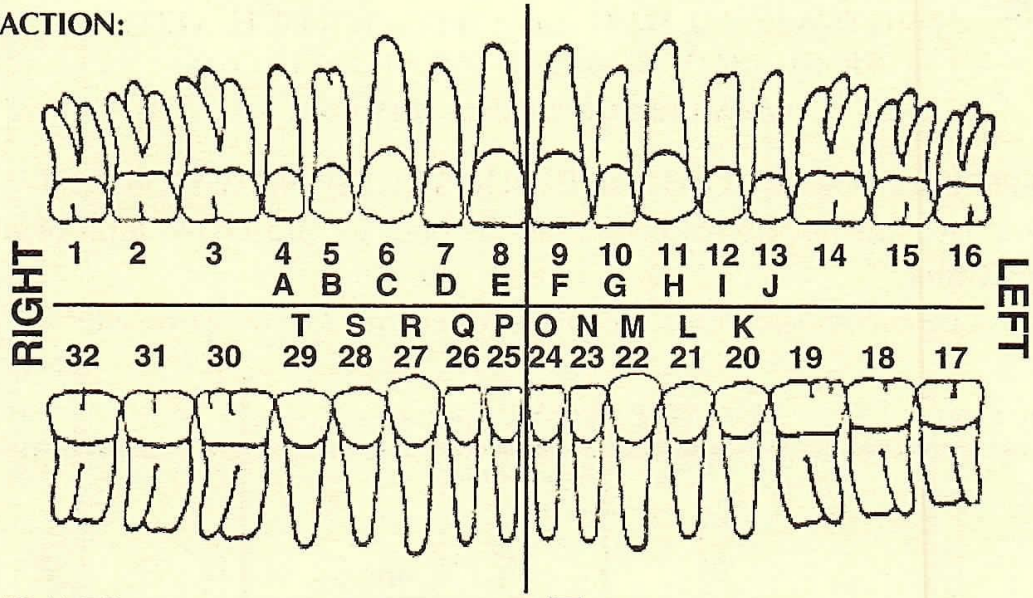
REFERRED BY: _____

DOCTOR'S TEL. #: _____

REASON FOR REFERRAL

CONSULTATION: _____ TREATMENT: _____

EXTRACTION:



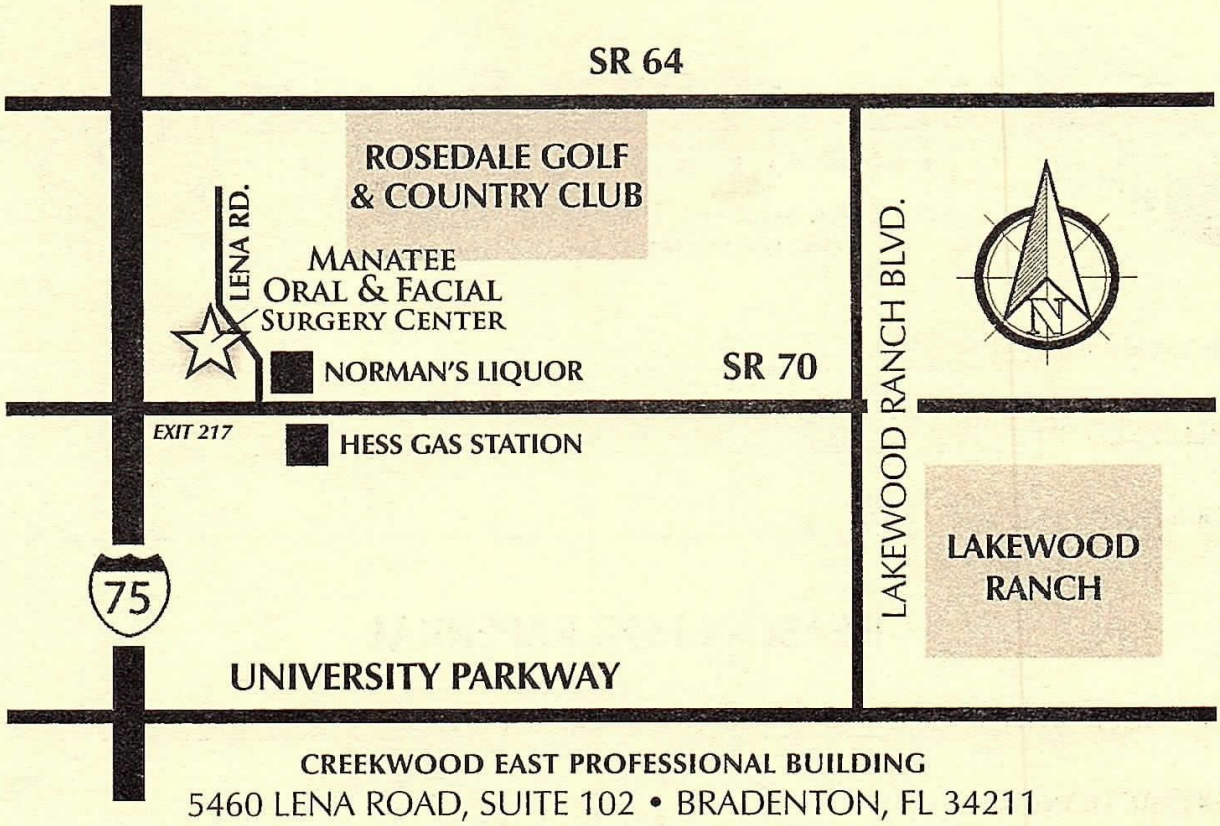
- ☐ IMPLANTS
- ☐ INFECTION
- ☐ LESION & EVALUATION
- ☐ ORTHOGNATHIC EVALUATION
- ☐ TMJ
- ☐ TRAUMA
- ☐ PRE-PROSTHETIC
- ☐ OTHER: _____

_____

CREEKWOOD EAST PROFESSIONAL BUILDING
5460 LENA ROAD, SUITE 102
BRADENTON, FL 34211
PHONE: (941) 755-6637
FAX: (941) 755-6636

4016 9th AVE. WEST
BRADENTON, FL 34205
PHONE: (941) 792-8900
FAX: (941) 792-4300

www.manateeoralsurgery.com



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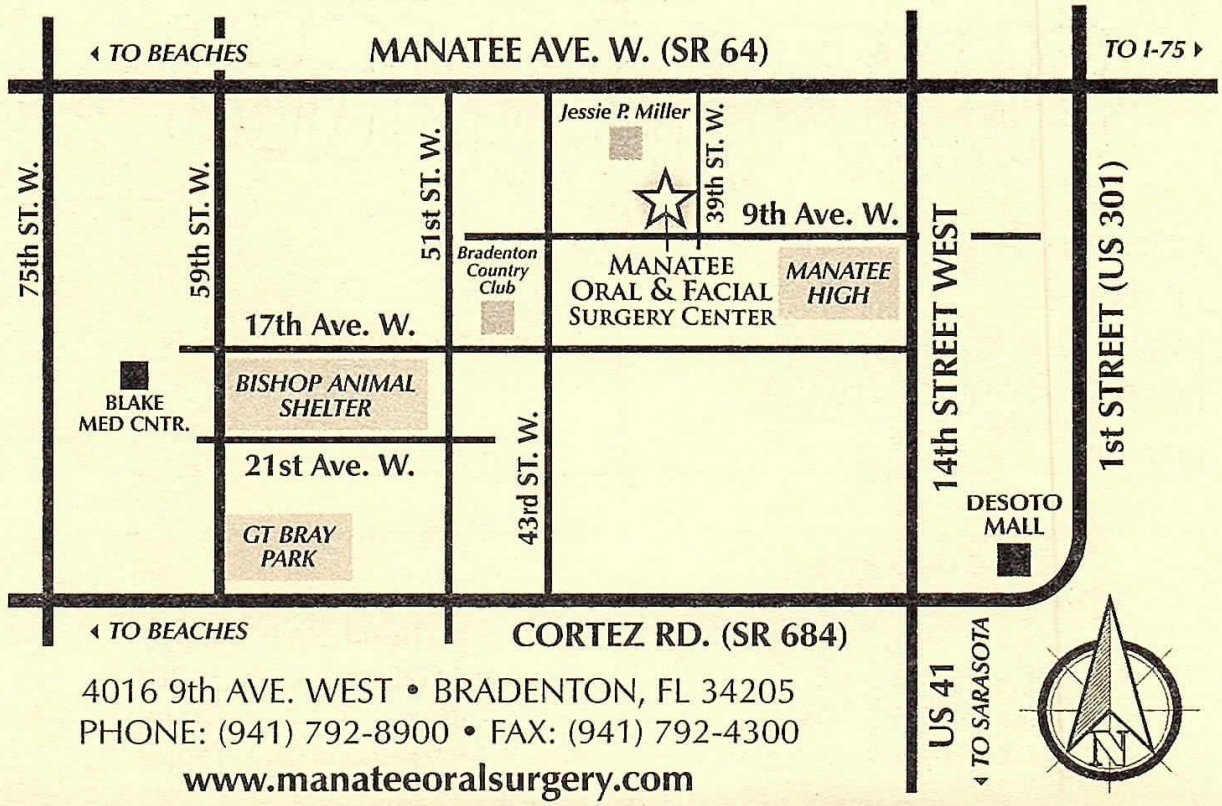
SPECIAL INSTRUCTIONS FOR PATIENTS RECEIVING IV SEDATION

1. Do not have anything to eat or drink 6 hrs prior to surgery. **No food or drink including water.**
2. You must be accompanied by somebody who can drive you home after surgery.



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