Chart #: _«Chart»___
FOR OFFICE USE ONLY

Patient Information

Patient Name: *«LName», «FName» «MI»* Date*: 11/26/2018*
Last, First MI (Preferred Name)

Gender: _«Gender»_____ Family Status: _«FamPos»_____

Social Security #: *«SS»* Birth Date: *«BirthDate»*

Phone (Home): *«HPhone»* (Work): *«WPhone»* Ext: *«WExt»* E-Mail: _____

Address: *«Street»* *«Street2»*
Street Apartment #

«City» *«State»* *«Zip»*
City State Zip Code

Health Information

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Abnormal Bleeding
- ☐ Allergies _____ _____
- ☐ Allergy: Aspirin
- ☐ Allergy: Codeine
- ☐ Allergy: Drug
- ☐ Allergy: Novocaine
- ☐ Allergy: Penicillin
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pain in Chest
- ☐ **Current Pregnancy** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Smoke
- ☐ Swollen Ankles
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:
- ☐ _____
- ☐ _____

- Please list any medications you are presently taking. _____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Who may we thank for your referral? ☐ Friend ☐ Relative ☐ Advertisement ☐ Other__«RefBy_Name», «RefBy_FName»___

Spouse or Responsible Party Information

Name: *«Guar_LName», «Guar_FName»*

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): «HPhone» (Work): _____ Ext: _____ Best time to call: _____

Address: «Street»
Street Apartment #

«City» «State» «Zip»
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: *«Emp_Name»* Occupation: _____

Address: *«Emp_Add1»* *«Emp_Street2»* *«Emp_Add2»* *«Emp_Phone»*
Street City, State Zip Code Phone

Insurance Information
(*For Office Use Only)*

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address:
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: «PIns_Name» _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address:
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: *«SIns_Name»* _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
There will be a $25 return check fee for all returned checks.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

_____ Date: _____
Please Print Name of Guarantor

Dr. Khanna's Missed, Canceled and Late Appointment Policy

The goal of this policy is to insure the following:

1. *Waiting time in the office will continue to be as short as possible, and we will continue to respect and value your time.*
2. *Our schedule will be controlled, so that when you call with an emergency we can continue to get you in quickly.*
3. *Minimization of missed appointments which lead to higher cost for everyone.*

Our policy is to call, email, and/or text every patient for confirmation 2 days prior to their scheduled appointment. Please let the front desk know if there is a specific way you wish to be notified. If you do not respond, we will call you again the next day and continue to try to reach you. If for some reason you can't make the appointment, please call us back and let us know so that we can make it available for other patients. Please note that we do not accept cancellations via text or email as it is an automated system. If you can make it, please let us know that you will be coming by either confirming through our automated system or calling the office. Our phone number is (301) 373-3230 and you can leave a message any time of the day or night.

Missed Appointments- Occasionally unavoidable things arise; car accidents, death in the family, etc.; so you will not be charged for your first missed appointments in any 12 month period. If you continue to schedule appointments and do not show up you, confirmed or not, will be charged a missed appointment fee of $50. Missing 3 appointments in any 12 month period will result in your dismissal from the practice.

Cancelled Appointments- If you need to cancel an appointment, please do so with a minimum of 24-hours' notice and we will be happy to reschedule you. If notice is given within less than 24 hours, you will be charged for a missed appointment.

Arriving Late- If you arrive late, we will do our best to accommodate you. However, you may be asked to reschedule for another day/time if seeing you will cause other patients to have to wait an unnecessary amount of time.

Our office is HIPAA compliant. If you would like a copy of the HIPAA Policy, please let us know.

X_____Date_____

Signature of guarantor of payment/responsible party