4032 McDermott Ste 200
PLANO TX 75024
Tel (214) 618–6250

Natural Smile Dentistry
Priya Mainker, DMD

Family and Cosmetic Dentistry
Invisalign Orthodontics
www.NaturalSmile.Com
Dr.Mainker@NaturalSmile.Com

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Preferred or Nick Name	Gender
				M / F
Soc Sec Num NNN-NN-NNNN	**Date of Birth MM/DD/YYYY**	**Marital Status**	**Email Address**	**Drivers License Number**

Home Address

Street	City	State	ZIP	Phone Number	Alternate Phone

Work Address

Street	City	State	ZIP	Phone Number	Alternate Phone

Emergency Contact

Name	Relationship	Phone Number	Alternate Phone	Work Number

INSURANCE INFORMATION

Primary Insured Person

Last Name	First Name	Middle Initial	Soc Sec Num	Date of Birth MM/DD/YYYY

Employer of the Primary Insured

Company Name	Street Address	City	State	ZIP	Phone Number

Insurance Plan

Insurance Carrier	Street Address	City, State, Zip	Phone Number	Group Number

Secondary Insurance Plan (Leave Blank if there is no secondary insurance)

Insurance Carrier	Street Address	City, State, Zip	Phone Number	Group Number

Assignment of benefits and signature on file

I hereby assign to Dr. Priya Mainker, Natural Smile Dentistry, P. A., payment of insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.	I authorize release of any information related to insurance claims filed on my behalf by Dr. Priya Mainker, Natural Smile Dentistry P. A.

I understand that in case I cancel or reschedule my appointment at less than 24 hours notice, there may be a fee charged to me.

How did you find out about Natural Smile Dentistry (Check the appropriate box and provide relevant info)

☐Internet search. Site: Phrase:	☐ Insurance Company	☐ Referred by patient. Name:	☐ Referred by another health care provider. Name:	☐ Other. Please Specify:

Please provide your driver's license, or other form of identification, and your insurance card(s) along with the completed form.

Today's Date	Print Full Name	Signature

Please fill out completely, sign and email to us at Dr.Mainker@NaturalSmile.Com

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Date:	Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:

HEALTH HISTORY FORM

LAST NAME	FIRST NAME	FIRST INITIAL

For the following questions please check whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Question	YES	NO	Don't Know	Question	Please provide answers
Do your gums bleed when you brush?	☐	☐	☐	How would you describe your current dental problem?	
Have you ever had orthodontic (braces) treatment?	☐	☐	☐	Date of your last dental exam:	
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Date of last dental x-rays:	
Do you have earaches or neck pains?	☐	☐	☐	What was done at that time?	
Have you had any periodontal (gum) treatments?	☐	☐	☐	How do you feel about the appearance of your teeth?	
Do you wear removable dental appliances?	☐	☐	☐		
Have you had a serious/difficult problem associated with any previous dental treatment?	☐	☐	☐		
If yes, explain:					

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If you answer yes to any of the 3 items below, please stop and return this form to the receptionist. Have you had any of the following diseases or problems?	YES	NO	Don't Know	Question	YES	NO	Don't Know
Active Tuberculosis?	☐	☐	☐	Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	☐	☐	☐
Persistent cough greater than a 3 week duration?	☐	☐	☐	If yes, Provide details of medications being taken: Prescribed: Over the Counter: Vitamins, natural or herbal preparations and/or diet supplements:			
Cough that produces blood?	☐	☐	☐	Date of last physical examination:			
Are you in good health?	☐	☐	☐	**Physician Information**			
Has there been any change in your general health within the past year?	☐	☐	☐	Name: Phone: ( ) -			
Are you now under the care of a physician?	☐	☐	☐	Address: City: St: Zip:			
If yes, what is/are the condition(s) being treated?	☐	☐	☐	**Question**	**YES**	**NO**	**Don't Know**
Have you had any serious illness, operation, or been hospitalized in the past 5 years? If yes, what is/was the illness or problem?	☐	☐	☐	Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐	☐
Do you drink alcoholic beverages? If Yes, how much alcohol you have consumed in last 24 hours? In last one week?	☐	☐	☐	Are you alcohol and/or drug dependent? If yes, have you received treatment? Choose One:	☐	☐	☐
Do you use drugs or other substances for recreational purposes? If Yes, list:: Frequency of use (daily, weekly, etc.): Number of years of recreational drug use:	☐	☐	☐	Do you use tobacco (smoking, snuff, chew)? If yes, how interested are you in stopping Choose One:	☐	☐	☐
Do you wear contact lenses?	☐	☐	☐				

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Are you allergic to or have you had a reaction to?	YES	NO	Don't Know
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food, Specify	☐	☐	☐
Other, Specify	☐	☐	☐
Metals, Specify	☐	☐	☐
To yes responses, specify type of reaction:			

	YES	NO	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If yes, when was this operation done?	☐	☐	☐
If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?			
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐
If yes, what antibiotic and dose?			
Contact info of prescribing physician or dentist:			
Name: Phone: ( ) -			
Address: City: St: Zip:			
WOMEN ONLY			
Are you or could you be pregnant?	☐	☐	☐
Nursing?	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐

Have you had any of these problems or deseases?	YES	NO	Don't Know		YES	NO	Don't Know
Abnormal bleeding	☐	☐	☐	Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	☐
Anemia	☐	☐	☐	Recurrent Infections If yes, indicate type of infection	☐	☐	☐
Arthritis	☐	☐	☐	Kidney problems	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	Mental health disorders. If yes, specify:	☐	☐	☐
Asthma	☐	☐	☐	Malnutrition	☐	☐	☐
Blood transfusion: If Yes, Date:	☐	☐	☐	Night sweats	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐	Neurological disorders. If yes, specify:	☐	☐	☐
Cardiovascular disease. If yes, specify below: ☐Angina ☐ Arteriosclerosis ☐ Artificial heart valves ☐ Congenital heart defects ☐ Congestive heart failure ☐ Coronary artery disease ☐ Damaged heart valves ☐ Heart attack ☐ Heart murmur ☐ High blood pressure ☐ Low blood pressure ☐ Mitral valve prolapse ☐ Pacemaker ☐ Rheumatic heart ☐ disease/Rheumatic fever	☐	☐	☐	Osteoporosis	☐	☐	☐
				Persistent swollen glands in neck	☐	☐	☐
				Respiratory problems. If yes, specify below ☐Emphysema ☐Bronchitis Other:	☐	☐	☐
				Severe headaches/migraines	☐	☐	☐

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Chest pain upon exertion	☐	☐	☐	Severe or rapid weight loss	☐	☐	☐
Chronic pain	☐	☐	☐	Sexually transmitted disease	☐	☐	☐
Disease, drug, or radiation-induced immunosurpression	☐	☐	☐	Sinus trouble	☐	☐	☐
Diabetes. If yes, specify below: ☐Type I (Insulin dependent) ☐Type II	☐	☐	☐	Sleep disorder	☐	☐	☐
				Sores or ulcers in the mouth	☐	☐	☐
Dry Mouth	☐	☐	☐	Stroke	☐	☐	☐
Eating Disorder, please spcify	☐	☐	☐	Systemic lupus erythematosus	☐	☐	☐
Epilepsy	☐	☐	☐	Tuberculosis	☐	☐	☐
Fainting spells or seizures	☐	☐	☐	Thyroid problems	☐	☐	☐
Gastrointestinal disease	☐	☐	☐	Ulcers	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐	Excessive urination	☐	☐	☐
Glaucoma	☐	☐	☐	Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Today's Date	Print Full Name	Signature at the time of check-in

Health History Updates

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WRITTEN FINANCIAL POLICY

Thank you for choosing Natural Smile Dentistry. Our mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Visa® or MasterCard®

We offer a **5%** courtesy accounting **adjustment** to patients who **pre- pay for their treatment with Cash, Credit Card or Check.**
_____(Pt initial)

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

In the event that you need dental treatment, is there another person (e.g. spouse, parent, etc.) who is involved in decisions regarding your healthcare and/or your financial decisions? YES____ NO____

If yes, please give their name and contact #:_____

Please note:

Natural Smile Dentistry requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

A 30-50% deposit is required to secure your treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

Statements are sent out January, March, May, July, September, and November.

A fee of $75 is charged for patients who miss or cancel more than 3 times in a calendar year without 48-hour notice.

Natural Smile Dentistry charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval.

[2]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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Privacy Practices

Note: You have the right to read our Privacy Practices Notices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our dental office's Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

Individual giving consent:

Patient Name: _____

Name of individual giving consent if other than patient:_____

Relationship to patient: _____

Address: _____

Telephone: _____

To The Individual" Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we will NOT be able to bill your dental insurance and we may decline to treat you.

Other Use of Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Person Involved in Care: By Signing this form, you will consent the office of Dr. Priya Mainker use of your dental care records to the following persons, including those involved in care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Please indicate below if you allow us to (CIRCLE EITHER YES OR NO:

YES NO ***Submit your dental insurance claims***
YES NO ***Send you a reminder postcard***
YES NO ***Leave a message on your answering machine at home or work***
YES NO ***Leave a message on you cell phone (_____) _____-_____***
YES NO ***Send a text reminder to your cell phone (_____) _____-_____***
YES NO ***Send an appointment reminder or message via email _____***
YES NO ***Leave a message with the following persons who may answer the phone at your home/work***

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

YES NO ***Confirm your upcoming appointment/ reschedule an appointment with the following people.***

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Office listed below. Revocation of this consent will not affect any action we took in reliance on this

authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent,

Contact Office: Dr. Priya Mainker

Telephone: 214-618-6250

Address: 4032 McDermott Drive, Ste 200. Plano, TX 75024

Acknowledgement of Receipt of Privacy Practices

I, _____, acknowledge that a copy of this office's Notice of Privacy Practices has been received/ read or been offered and refused. I also have had full opportunity to read and consider the consents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this consent is signed by a personal representative/parent on behalf of the individual, complete the following:

Personal Representative's/Parent Name: _____

Relationship to Patient: _____

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Release for Pictures

I am aware that Natural Smile Dentistry will take color oral photographs of my mouth in connection with dental procedures. These photographs would show only my mouth (interior and exterior) and not my face or any other features by which I could be identified.

I give permission to use these photographs in advertising in various media such as web page and magazines to show the quality of dental services.

Sign Name

Signature

_____

Date _____