40 West 73rd Ave. Merrillville, IN 46410
P: (219)769-3305 F: (219)769-4674
Dr. Manoj K. Bahl
info@exceldentalstudio.com

ABOUT YOU

Adult - Page 1

TODAY'S DATE: ______________ EMAIL ADDRESS: ______________

NAME ______________
FIRST MI LAST NAME MR MRS MS DR

I PREFER TO BE CALLED: ______________ ☐ MALE ☐ FEMALE

BIRTH DATE: ______________ AGE: ______________ SS#: ______________

HOME ADDRESS: ______________ APT / CONDO#: ______________

____
CITY STATE ZIP

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

HOME# :(____)______________ PAGER / CELL #: (____)______________

WK.#: (_____)______________ EXT#: ______________ DL#: ______________

HOW WOULD YOU LIKE TO BE CONTACTED? ☐ HOME PHONE ☐ E-MAIL ☐ CELL PHONE ☐ TEXT MSG

WHERE AND WHEN ARE BEST TIMES TO REACH YOU? ☐ MORNING ☐ AFTERNOON ☐ EVENING

EMPLOYER: ______________

EMPLOYER'S ADDRESS: ______________
STREET CITY STATE / ZIP

HOW LONG THERE: ______________ OCCUPATION: ______________

WHOM MAY WE THANK FOR REFERRING YOU? ______________

OTHER FAMILY MEMBERS SEEN BY US: ______________

PREVIOUS / PRESENT DENTIST: ______________
NAME CITY (STATE) PHONE

LAST VISIT DATE: ______________

SPOUSE INFORMATION

NAME: ______________ SOCIAL SEC #: ______________

EMPLOYER: ______________ BIRTH DATE: ______________

ADDRESS: ______________ HOME PHONE#: (_____)______________

CITY, ST, ZIP: ______________ CELL PHONE#: (____)______________

DRIVERS LICENSE#: ______________ WORK PHONE#: (____)______________

IN THE EVENT OF EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE CAN CALL?

HIS/ HER NAME: ______________ RELATION: ______________

HOME PHONE: (_______)______________ CELL PHONE : (___)______________ WORK PHONE : (______)______________

PATIENT'S NAME: ______________________

PERSON RESPONSIBLE FOR ACCOUNT: ______________________ PHONE: (___) ______________________

BILLING ADDRESS: ______________________

RELATIONSHIP: ______________________ SS#: ______________________

BIRTH DATE: ______________________ DL#: ______________________

PRIMARY INSURANCE

DO YOU HAVE DENTAL INSURANCE COVERAGE? : ☐ YES ☐ NO

INSURANCE COMPANY NAME: ______________________

ADDRESS / P.O. BOX: ______________________

CITY / ST / ZIP: ______________________

INSURANCE COMPANY TELEPHONE: (_____) ______________________ GROUP / POLICY#: ______________________

SUBSCRIBER / INSURED NAME: ______________________ BIRTH DATE: ______________________

INSURANCE IDENTIFICATION NUMBER: ______________________

RELATIONSHIP TO SUBSCRIBER / POLICY HOLDER (CIRCLE ONE): SELF SPOUSE PARTNER CHILD OTHER ______________________

SUBSCRIBER / INSURED EMPLOYER: ______________________

ADDRESS: ______________________ CITY / ST / ZIP: ______________________

SECONDARY INSURANCE

DO YOU HAVE SECONDARY DENTAL INSURANCE COVERAGE? ☐ YES ☐ NO

INSURANCE COMPANY NAME: ______________________

ADDRESS / P.O. BOX: ______________________

CITY / ST / ZIP: ______________________

INSURANCE COMPANY TELEPHONE: (_____) ______________________ GROUP / POLICY# : ______________________

SUBSCRIBER / INSURED NAME: ______________________ BIRTH DATE: ______________________

INSURANCE IDENTIFICATION NUMBER: ______________________

RELATIONSHIP TO SUBSCRIBER/POLICY HOLDER (CIRCLE ONE): SELF SPOUSE PARTNER CHILD OTHER: ______________________

SUBSCRIBER / INSURED EMPLOYER: ______________________

ADDRESS: ______________________ CITY / ST / ZIP: ______________________

DENTAL HISTORY

REASON FOR APPOINTMENT: ____________________

DO YOU DESIRE COMPLETE AND THOROUGH DENTAL CARE OR
TREATMENT OF A SPECIFIC PROBLEM ONLY? ____________________

HAVE YOU HAD REGULAR PREVENTIVE DENTAL CARE IN THE PAST? ☐ YES ☐ NO

WHEN WAS YOUR LAST APPOINTMENT? ____________________

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR SMILE? ☐ YES ☐ NO

DO YOU FEEL SAVING YOUR TEETH IS WORTH THE EFFORT? ☐ YES ☐ NO

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD BE? ____________________

HAVE YOU EVER HAD ORTHODONTIC TREATMENT (BRACES)? ☐ YES ☐ NO

HAVE YOU CONSIDERED STRAIGHTNING YOUR SMILE? ☐ YES ☐ NO

HAVE YOU EVER HAD ANY WISDOM TEETH REMOVED? ☐ YES ☐ NO

DO YOU WEAR REMOVABLE PARTIAL OR DENTURE? UPPER_______ ☐ YES ☐ NO YEAR MADE: ____________

LOWER _______ ☐ YES ☐ NO YEAR MADE: ____________

ARE YOU SATISFIED WITH IT? ☐ YES ☐ NO

HAVE YOU EVER HAD INJURIES TO YOUR MOUTH? ☐ YES ☐ NO

ARE YOUR GUMS EVER SORE OR DO THEY BLEED? ☐ YES ☐ NO LAST CLEANING: ____________

DO YOU HAVE LOOSE TEETH? ☐ YES ☐ NO

HAVE YOU EVER BEEN TOLD THAT YOU HAVE GUM DISEASE (PYORRHEA)? ☐ YES ☐ NO

DO YOU HAVE ANY SORE OR SENSITIVE TEETH? ☐ YES ☐ NO

DO YOU EVER NOTICE SOUNDS OR PAIN IN THE JAWS JOINT? ☐ YES ☐ NO

HAVE YOU EVER BEEN TOLD THAT YOU HAVE A PROBLEM WITH YOUR BITE? ☐ YES ☐ NO

DO YOU CLENCH OR GRIND YOUR TEETH? ☐ YES ☐ NO

HAVE YOU EVER HAD ANY TROUBLE WITH PREVIOUS DENTAL TREATMENT? ☐ YES ☐ NO

DO YOU HAVE ANY CONCERNS THAT WE SHOULD KNOW ABOUT? ____________________

WOULD YOU BE INTERESTED IN FREE TOOTH WHITENING FOR LIFE? ☐ YES ☐ NO

MEDICAL HISTORY

DO YOU HAVE A PERSONAL PHYSICIAN? ☐ YES ☐ NO

PHYSICIAN NAME: ____________________ PHONE: (____)____________

CITY / STATE: ____________________ DATE OF LAST VISIT: ____________

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

PLEASE EXPLAIN: ____________________

PATIENT'S NAME: ______________________

MEDICAL HISTORY

Please answer the following questions to give us a complete Medical History.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: ______________________

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? ○ Yes ○ No If yes, please explain: ______________________

Do you ever taken Fosamax, Boniva, Actonel or Any medication containing bisphonates? ○ Yes ○ No ______________________

Do you use tobacco? ○ Yes ○ No Do you use controlled substances? ○ Yes ○ No Are you on special diet? ○ Yes ○ No

Women: Are you Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No nursing ○ Yes ○ No

Are you allergic any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ SULFA Drug ☐ Other, if yes, please explain ______________________

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

AIDS/HIV Positive	○ Yes	○ No	Cortisone Medicine	○ Yes	○ No	Hemophilia	○ Yes	○ No	Radiation Treatments	○ Yes	○ No
Alzheimer's Disease	○ Yes	○ No	Diabetes	○ Yes	○ No	Hepatitis A	○ Yes	○ No	Renal Dialysis	○ Yes	○ No
Anaphylaxis	○ Yes	○ No	Drug Addiction	○ Yes	○ No	Hepatitis B or C	○ Yes	○ No	Rheumatic Fever	○ Yes	○ No
Anemia	○ Yes	○ No	Easily Winded	○ Yes	○ No	Herpes	○ Yes	○ No	Rheumatism	○ Yes	○ No
Angina	○ Yes	○ No	Emphysema	○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Scarlet Fever	○ Yes	○ No
Arthritis/Gout	○ Yes	○ No	Epilepsy or Seizures	○ Yes	○ No	High Cholesterol	○ Yes	○ No	Shingles	○ Yes	○ No
Artificial Heart Valve	○ Yes	○ No	Excessive Bleeding	○ Yes	○ No	Hives or Rash	○ Yes	○ No	Sickle Cell Disease	○ Yes	○ No
Artificial Joint	○ Yes	○ No	Excessive Thirst	○ Yes	○ No	Hypoglycemia	○ Yes	○ No	Sinus Trouble	○ Yes	○ No
Asthma	○ Yes	○ No	Fainting Spells/Dizziness	○ Yes	○ No	Irregular Heartbeat	○ Yes	○ No	Spina Bifida	○ Yes	○ No
Blood Disease	○ Yes	○ No	Frequent Cough	○ Yes	○ No	Kidney Problem	○ Yes	○ No	Stomach/Intestinal Disease	○ Yes	○ No
Blood Transfusion	○ Yes	○ No	Frequent Diarrhea	○ Yes	○ No	Leukemia	○ Yes	○ No	Stroke	○ Yes	○ No
Breathing Problem	○ Yes	○ No	Frequent Headaches	○ Yes	○ No	Liver Disease	○ Yes	○ No	Swelling of Limbs	○ Yes	○ No
Bruise Easily	○ Yes	○ No	Genital Herpes	○ Yes	○ No	Low Blood Pressure	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Cancer	○ Yes	○ No	Glaucoma	○ Yes	○ No	Lung Disease	○ Yes	○ No	Tonsillitis	○ Yes	○ No
Chemotherapy	○ Yes	○ No	Hay Fever	○ Yes	○ No	Mitral Valve Prolapse	○ Yes	○ No	Tuberculosis	○ Yes	○ No
Chest Pains	○ Yes	○ No	Heart Attack/ Failure	○ Yes	○ No	Osteoporosis	○ Yes	○ No	Tumors or Growths	○ Yes	○ No
Cold Sores/Féver Blisters	○ Yes	○ No	Heart Murmur	○ Yes	○ No	Pain in Jaw Joints	○ Yes	○ No	Ulcers	○ Yes	○ No
Congenital Heart Disorders	○ Yes	○ No	Heart Pacemaker	○ Yes	○ No	Parathyroid Disease	○ Yes	○ No	Venereal Disease	○ Yes	○ No
Convulsions	○ Yes	○ No	Heart Trouble/Disease	○ Yes	○ No	Psychiatric Care	○ Yes	○ No	Yellow Jaundice	○ Yes	○ No

Have you ever have serious illness not listed above? ○ Yes ○ No

Please discuss any other serious medical problem we should be aware of ______________________

____

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT: ______________________ DATE: ______________

FOR OFFICE USE ONLY

1. Date: ______________ Comments / Changes ______________________

Signature: ______________________

2. Date: ______________ Comments / Changes ______________________

Signature: ______________________

3. Date: ______________ Comments / Changes ______________________

Signature: ______________________

EXCEL DENTAL STUDIO – Manoj K. Bahl, DDS, PC
FINANCIAL – OFFICE POLICY

The following is a statement of our **FINANCIAL POLICY** that we require you to read and sign before treatment.

- We cannot bill your insurance company unless you provide us with the necessary information. As a courtesy to you, we will submit claims to your insurance provider.

- Your insurance is a contract between you and your insurance company. We are not part of that contract.

- Most insurance companies only pay a percentage of the cost, you are responsible for the remainder.

- Please be aware that some of the services provided may be non-covered services by your insurance.

- Our practice is committed to providing the best treatment for our patients. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. It is important for you to call your insurance company and ask if there are any clauses or waiting periods.

I/we hereby authorize the assignment of any insurance benefits to Dr. Manoj K. Bahl, DDS., dba Excel Dental Studio and agree to be liable for the payment of all dental services performed and not paid by insurance or other benefits

I/we also agree to pay all collection costs, interest and reasonable attorney fees in the event this account or any future account of mine/ours is turned over to our attorneys for collection, all without relief from valuation and appraisement laws should I/we fail to pay any amounts not paid by insurance or other benefits.

Those who carry no insurance are required to pay in full when services are rendered.

Please understand that payment on your bill is considered a part of your treatment.

OFFICE POLICY

-When making an appointment, we feel it is a commitment to your dental health. Please make sure you keep your appointment and arrive on/before your scheduled time.

-If you need to change your appointment, we require 24 hour notice. Failed appointments are subject to a $30 fee.

-This is a fee for service office and requires payment in full at time of service. If you have insurance, your estimated patient portion is due at the time of service.

-Your health is our primary concern. It is necessary for you to routinely update your health/medical history with us. Please inform us of any changes in medications, surgeries, allergies, etc.

____
Patient Name

____________________________ ____________________________ __________
Signature of Responsible Party | Printed Name | Date

EXCEL

40 West 73rd Ave Merrillville, IN 46410

P: (219) 769-3305 F: (219) 769-4674

Dr. Manoj K. Bahl

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices. Our legal duties.
And your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect 4/14/03. And will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time. Provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment payment, and healthcare operations. For example:

Treatment: we may use or disclose your health information to obtain payment to a physician or other healthcare provider providing treatment to you.

Payment: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Healthcare operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, and accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: we may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present , then prior to use or disclosure of your health information. We will provide you with an opportunity to object to such uses or disclosures, in the event of your incapacity or emergency circumstances, we will disclose practice to make reasonable interferences of your best internet allowing person to pick up tiled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communication without your written authorization.

Required by Law: we may use or disclose your health information when we required to do so by law.

Abuse or Neglect: we may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim or other crimes, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or life health or safety of others.

Acknowledgement of Receipt of Notice of Privacy Practices

Excel Dental Studio

40 West 73rd Avenue, Merrillville, IN 46410

(219)769-3305 Fax: (219)769-4674

The Health Insurance Portability and Accountability Act (HIPAA) requires us to give you a notice of our privacy practices and to acknowledge your receipt of the notice.

What is the **Notice of Privacy Practices?**

The Notice of Privacy Practices explains how your protected health information may be used or disclosed by us. In addition, it explains your rights with regard to your protected health information, as well as our legal responsibilities.

1) I have been provided a copy of the Notice of Privacy Practices:

____ ______________

Print Name Date of Birth

________________________________ ____________ ______________

Signature of Patient or Patient Representative Relationship Date

1) I authorize Excel Dental Studio to share my medical information with the person(s) listed below:

__Yes __No ___Spouse: Name____

__Yes __No ___Children: Name____

____

__Yes __No ___Friend: Name ____

__Yes __No ___Other: Name ____