RAJIVA TIRTHA & ASSOCIATES   103 W CLINTON ST DURAND MI 48429   (989) 288-6165

PATIENT NAME: ____ PHONE: ______________________

PREFERRED NAME____

ADDRESS____

CITY____STATE____________ZIP____________________

CELL PHONE#____________________________________EMAIL______________________________________

D.O.B.________________________________ S/M/D/W   M/F   SS#_________________________________

NAME OF RESPONSIBLE PARTY____

RESPONSIBLE PARTY D.O.B__________________________ SS#______________________________________

MAY WE CONTACT YOU AT WORK? YES____NO____ WORK PHONE_________________________________

PERSON TO CONTACT IN CASE OF EMERGENCY____________________________PHONE________________

PRIMARY INSURANCE

SUBSCRIBER____D.O.B._________________________

INSURANCE COMPANY____S.S. #_________________________

EMPLOYER NAME____

SECONDARY INSURANCE

SUBSCRIBER____D.O.B._________________________

INSURANCE COMPANY____S.S. #_________________________

EMPLOYER NAME____

I HERE BY AUTHORIZE PAYMENT TO GO DIRECTLY TO RAJIVA TIRTHA DDS & ASSOCIATES FROM MY INSURANCE COMPANY FOR SERVICES RENDERED. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COST OF TREATMENT, WHETHER MY INSURANCE COMPANY PAYS OR NOT. I AM RESPONSIBLE FOR KNOWING WHAT BENEFITS MY INSURANCE COMPANY COVERS AND WILL SETTLE ANY DISPUTE WITH THEM MYSELF. ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.**
I UNDERSTAND THAT IF I NEED TO CANCEL AN APPOINTMENT I MUST CALL WITH 48 HOUR NOTICE DURING BUSINESS HOURS TO AVOID CANCELLATION OR MISSED APPOINTMENT CHARGES.
I UNDERSTAND THAT IF A CHECK IS RETURNED FOR NONSUFFICIENT FUNDS THAT I WILL BE CHARGED A FEE..
I AUTHORIZE THE DENTIST TO RELEASE MY DENTAL/MEDICAL HISTORIES AND OTHER INFORMATION ABOUT MY DENTAL TREATMENT TO THIRD PARTY PAYERS AND/OR HEALTH PROFESSIONALS.
I UNDERSTAND THAT AN ADULT MUST ACCOMPANY ANY MINOR CHILD TO ALL APPOINTMENTS. I ALSO UNDERSTAND THAT IN A DIVORCE SITUATION THE ADULT ACCOMPANYING THE MINOR IS RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE.
THE INFORMATION I HAVE GIVEN ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE____DATE__________________

HEALTH HISTORY

Patient Name:___________________________ Physicians Name:_________________________________

Physician's Phone:____________________________ Date of Last Physical Exam:_____________________

Have you been hospitalized in the last 2 years? Yes______________________ No ____________________

Have you been under the care of a physician in the past 2 years? Yes_____________ No_______________

Are you allergic to penicillin, aspirin, codeine, local anesthetic, latex, metals, or any other medications? Please list:____

Have you ever had excessive bleeding requiring special treatment?_________________________________

Are you in pain or discomfort at this time? ____

Do you habitually grind or clench your teeth during the day or night? ____________________________

Is there anything that you dislike about your smile? ____

Do you have any medical condition(s) that have required you to take antibiotics prior to dental treatment now or in the past? ____

Circle any of the following you have had or presently have:

***Antibiotic premedication may be required prior to your appointment**.

***Artificial Hip, Knee, or Joint**
***Infective Endocarditis**
***Prosthetic Heart Valve**
Alcoholism
Allergies/Hives/Hay Fever
Anemia
Angina Pectoris
Arthritis
Bleeding Disorders
Blood Transfusion
Bruise Easily
Cancer- Type ___________/YR________
Chew/Snuff/Tobacco
Cold Sores/Herpes

Congenital Heart Lesions
Cortisone Medication
Diabetes
Drug Addiction
Emphysema
Epilepsy
Fainting/Dizzy Spells
Glaucoma
Heart Disease
Heart Failure
Heart Murmur
Heart Pace Maker
Heart Surgery
Hepatitis- Type _____

HIV Positive, ARC, AIDS
High Blood Pressure
Jaundice
Kidney Disorder
Liver Disease
Mitral Valve Prolapse
Radiation/Chemo
Rheumatic Fever
Sickle Cell Disease
Smoke- pk/day_____
Stroke
Sinus Problems
Tuberculosis
***Any type of implant/transplant**

Please list all current medications, vitamins, or herbal supplements:

____

____

Is there anything to your medical or dental history that you have not indicated? ____________________

____

WOMEN: Are you pregnant? Yes/No Are you nursing? Yes/No Are you taking birth control pills? Yes/No

I have reviewed my medical history and the above information is accurate.

Signature____Date__________

RAJIVA TIRTHA & ASSOCIATES, P.C.

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, ____, HAVE RECEIVED A COPY OF THIS OFFICE NOTICE OF PRIVACY PRACTICES.

____
(PLEASE PRINT PATIENTS NAME)

____
(SIGNATURE OF PATIENT / PARENT /GUARDIAN)

____
(DATE)

OFFICE USE

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF OUT NOTICE PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

______ INDIVIDUAL REFUSED TO SIGN
______ COMMUNICATION BARRIERS PROHIBITED OBTAINING ACKNOWLEDGEMENT
______ AN EMERGENCY SITURATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT
______ OTHER (PLEASE SPECIFY)
____
____
____
____