Smile Brite Dental-Naushil Desai D.M.D., INC.
600 South Euclid Street Anaheim, CA 92802

This information is necessary for our files and will be considered **CONFIDENTIAL** Date___________________

Patient Information

Patient's Name____Age_________ D.O.B.__________ □Male □Female
Last First Initial

If Patient is a minor, give name of parent or legal guardian____Relationship______________________

Residence Address____For how long?_______ □Own □Rent
Street City Zip

Patient is: □Married □Single □Divorced □ Separated □Widowed □Minor Email____

Driver's License No. ________________ Social Security No. _______________ Res. Phone (____) _____________Cell Phone (____) _____________

Employed by____How Long? _________Occupation_______________________

Business Address____ Bus. Phone (____) ____________
Street City Zip

Emergency Contact____ Relationship_________________________

Complete Address____ Res. Phone (____) ______________
Street City Zip

Name of Physician____(_____)___________
Address Telephone

Former Dentist____(_____)___________
Address Telephone

Are You Changing Dentists?___________ ______________________________________Do you wish to speak to the doctor privately? □ Yes □ No

Purpose of Appointment?____

Is this visit for Emergency Dental Care? □Yes □No If yes Explain:____

Whom May we thank for referring you?____

Financial Information

Person Responsible for this account____Relationship________________(____)______________
Telephone

Address____
Street City Zip

PREFERENCE OF PAYMENT □ Cash on day of treatment □Visa/M/C No.________________________________Expiration date ______________

Name of insurance company (primary insurance)____ ______________________________

____
Insured person's name (Self/Spouse/Parent) D.O.B. Relationship Soc. Sec. No.

____
Name of Group Dental Plan Group No. Plan No. Name of Union Local

Name of insurance company (secondary insurance)____

Insured person's name____
D.O.B. Relationship Soc. Sec. No.

____
Name of Group Dental Plan Group No. Plan No. Name of Union Local

Terms and Conditions

As a condition of treatment by this office, I understand 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 service preformed without prior financial arrangements, must be paid for in cash at the time services are preformed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. **ASSIGNMENT of INSURANCE**: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1.5% per month (18% per annum; but in no event more that the maximum rate permissible under state law) will be charged on the unpaid principle balance on all accounts not paid within 60 days of treatment date. I understand that the fee estimate listed for this dental case (Proposed Treatment Plan) is subject to change. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff , 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 billed unless objected to by me, in writing within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees. I grant permission to you, or your assigns, 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 agree to their content:

Signed ____ Date__________________________

Health Questionnaire

These questions are for your benefit and assure that treatment will take into consideration your past and present health status.
Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.
Please answer each question. Check the appropriate box and/or circle **YES** or **NO** where applicable.

MEDICAL HISTORY

1. Are you in good health?... Yes No
2. Date of your last physical examination______________________________
3. Are you now under the care of a physician?... Yes No
   If so, what condition is being treated? ______________________________
4. Have you ever had any serious illness or operation?... Yes No
   If so, what illness or operation? ______________________________
5. Have you ever been hospitalized?... Yes No
   If so, what was the problem? ______________________________
6. Are you taking any □ medications, □ drugs or □ herbs? .... Yes No
   If so, what? ______________________________
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? □ Yes □No If so, what? ______________________________
8. Have you ever been premedicated with antibiotics for your dental treatment? .... Yes No
9. Are you sensitive or allergic to any drugs or materials? □ Penicillin; □ Tetracycline; □ Sulfa Drugs; □ Aspirin; □ Codeine; □ Latex; □ Other;.................Yes No
   If Other, what drugs? ______________________________
10. Do you have or have you had any of the following: (Please circle '**Y**' for Yes or '**N**' for No-answer all conditions):

Y N Anemia	Y N Implant(s)	Y N Head Injuries	Y N Drug Addiction	Y N Blood Transfusion	Y N Excessive Bleeding	Y N X-ray or Cobalt Treatment
Y N Herpes	Y N Headaches	Y N Heart Failure	Y N Kidney Disease	Y N Joint Replacement	Y N Mitral Valve Prolaspe	Y N Radiation Treatment of any kind
Y N Stroke	Y N Glaucoma	Y N Scarlet Fever	Y N Chemotherapy	Y N Nervous Disorders	Y N High Blood Pressure	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Ulcers	Y N Tonsillitis	Y N Sinus Trouble	Y N Stomach Ulcers	Y N Tumors or Growths	Y N HIV Related Complex	Y N Acquired Immune Deficiency Syndrome
Y N Diabetes	Y N Hemophilia	Y N Heart Murmur	Y N Angina Pectoris	Y N Allergies or Hives	Y N Respiratory Disease	Y N TMJ (Temporomandibular Syndrome)
Y N Arthritis	Y N Cold Sores	Y N Liver Disease	Y N Mental Disorder	Y N Pain in Jaw Joints	Y N Epilepsy or Seizures	Y N Taking Bisphosphonates e.g.
Y N Asthma	Y N Emphysema	Y N Blood Disease	Y N Thyroid Disease	Y N Artificial Prosthesis	Y N Psychiatric Treatment	(Atelvia, Actonel, Aredia, Aclasta, Binosto,
Y N Cancer	Y N Rheumatism	Y N Heart Aliments	Y N Fainting Spells	Y N Sickle Cell Disease	Y N Hepatitis or Jaundice	Boniva, Didronel, Fosamax, Reclast, Skelid
Y N Seizures	Y N Chicken Pox	Y N Heart Attack	Y N Rheumatic Fever	Y N Cortisone Medicine	Y N Difficulty Swallowing	Zometa)
Y N Hay fever	Y N Bruise Easily	Y N Cerebral Palsy	Y N Tuberculosis (T.B.)	Y N Allergies to Metals	Y N Congenital Heart Lesions	Y N Other ______________

11. Do you have any disease, condition or problem not listed that you think we should know about?... Yes No
    If so, what? ______________________________
12. Do you wear a cardiac pacemaker, or have you had heart surgery? .... Yes No
13. Do you smoke? If yes, how much? ___________ □ Cigarettes □ Cigars □ Packs per day .... Yes No
14. Have you ever taken the drugs □ Fen-Phen □ Redux or any □ diet drugs ? .... Yes No
15. (Women) Are you pregnant? If so how many months?______________________________
16. (Women) Do you have any problems associated with your menstrual period?... Yes No
17. (Women) Do you take any birth control medication or hormones? .... Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? .... Yes No
2. Have you ever had unfavorable reaction from a local anesthetic?... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? .... Yes No
   If so, explain? ______________________________
4. How long since your last full mouth X-Rays? _________Weeks _________Months _________ Years
5. How long since your last dental treatment? _________Weeks _________Months _________ Years
6. Does dental treatment make you nervous? □ Slightly □ Moderately □ Extremely? .... Yes No

□ I hereby acknowledge I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changes in any way. □ Patient refused/unable to sign because____________________________.
□ I have reviewed a copy of the **DENTAL MATERIALS FACT SHEET** as required by law.
To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Reviewed by _________________ Lic#_____________ Date_________

A Date_____________ **A Signature** ______________________________

B UPDATE- Since your last visit A:
Are you under the care of a physician? .... Yes No
Please note changes in health since last visit. If no changes write "NONE"
____
Date ______________ **Signature**______________________________

C UPDATE- Since your last visit B:
Are you under the care of a physician? .... Yes No
Please note changes in health since last visit. If no changes write "NONE"
____
Date ______________ **Signature**______________________________

D UPDATE- Since your last visit C:
Are you under the care of a physician? .... Yes No
Please note changes in health since last visit. If no changes write "NONE"
____
Date ______________ **Signature**______________________________

Staff Reviewed
B: ________
Date: ________
C: ________
Date: ________
D: ________
Date: ________

CANCELLATION POLICY:

Our office policy is to schedule appointment times individually, for each patient to receive adequate time with the doctor. We make every effort to run on time and do not overbook our schedule. We respect our patients' time and request that you respect our time as well.
We request that you contact our office at least 48 hours in advance to cancel and reschedule an appointment. This allows us to better accommodate emergency patients, as well as manage our time.
Patients who cancel less than 48 hours in advance and/or "no-show" for scheduled appointments will be charged a cancellation fee of $50.00.

I have read and understand the above cancellation policy.

Signature ______________________________

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations a may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:
Authorization must be signed by the patient or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed______________________________ **Date**_____________________ **Relationship to patient**______________________