RIVERDALE DENTAL CENTER

MEDICAL HISTORY

DR. NIMISH PATEL
6650 GA HWY 85
RIVERDALE, GA 30274

Name:	Date:
Address: Apt:	Birthdate: SEX:
City: Zip:	S.S.#:
Employed by:	Spouse's Name:
Hm #: Wk#:	Spouse Employed by:
Cell#:	Spouse Wk#:
Emergency contact - friend or relative	Spouse Cell#:
Name:	Patient's Physician:
Phone#:	
Patient's Insurance:	Policy Holder S.S. #:
Spouse's Insurance:	**PATIENT REFERRED BY:**

Please circle the following:	YES	NO
1. Have you had any serious illnesses (hospitalized)?	YES	NO
2. Are you under the care of a physician at present?	YES	NO
If so for what?		
3. Do you have AIDS?	YES	NO
3a. Does someone you close to you have AIDS?	YES	NO
4. Are you taking any medicines or drugs?	YES	NO
Please list:		
5. Are you allergic to any medicines or drugs?	YES	NO
Please list:		
6. DO YOU TAKE ASPIRIN, GOODIES, BC, OR BLOOD THINNERS?	YES	NO
7. (Female) Are you pregnant?	YES	NO
8. Do you smoke?	YES	NO
9. Have you been out of the country in the last month?	YES	NO
Which country?		

Have you ever had any of the following? If so, circle.

Heart Disease	Liver Disease	Fainting or Spells
Heart Attack	Hepatitis A,B, or C	Convulsions
Heart Murmur	Jaundice	Seizures
Congenital Heart Defect	Stomach Ulcer	Allergies
Chest Pain	Kidney Disease	Diabetes Type I or II
Rheumatic Fever	Thyroid Disease	Sinusitis
Rheumatic Heart Disease	Shortness of Breath	Arthritis
HIGH or LOW Blood Pressure	Tuberculosis	Anemia
Stroke	Swelling of Hands & Feet	Asthma
Bleeding Disease	Psychiatric Treatment	Glaucoma

PAYMENT TO BE MADE BY:_____CASH_____CHARGE* * MC,VISA,DISCOVER,AMEX

Welcome to the Riverdale Dental Center

The staff and I want your visit here to be as comfortable as possible, so if there is something we can do to make your visit more pleasant, please let us know.

Scheduling of appointments is necessary in order for the office to run smoothly and efficiently. We make every effort to stay on time with these appointments. If you absolutely must break an appointment, please give us a 48-hour notice. This will allow us to schedule another patient that is waiting for treatment. We will try to confirm your appointment two weeks before and also the working day before. We ask the patients to please confirm with us both times that you are able to keep this appointment. **If we have not been notified of a cancellation or the need to reschedule your appointment, there is a $25 charge.**

Our financial policy is as follow: Cash patients are expected to pay cash or credit card the day the service is rendered unless specific arrangements are made prior to services being rendered. **We file insurance as a courtesy to you. We are not responsible for collecting from the insurance companies - that is the patients responsibility**. We will accept assignment of benefits. **Most dental insurance plans do not cover 100% of the cost of your treatment.** Because of this and the extreme delay in receiving payments from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will file your insurance the date the service is rendered. **We will estimate as closely as possible your coverage, but until we actually receive the payment from the insurance company, it is just an estimate.** Not all dental services are a covered benefit in all contracts. We will assist you in dealing with your insurance company but the ultimate responsibility lies with you. After 90 days from the date of service the balance will be due in full from you.

Contracts may be set up with a patient to facilitate your treatment plans. Ask our office staff for details if you need alternate financial arrangements before treatment is started.

Feel free to ask any questions that remain unanswered either before or after treatment. We wish to be of assistance if we can.

Sincerely,
Nimish Patel, D.M.D.

I hereby authorize and assign my insurance benefits to be paid directly to Dr. Nimish Patel, P.C. for any and all work performed. To the best of my knowledge the above confidential information is true. If any above named patient is a minor, I also give my permission of treatment. You must be employed to be listed as a responsible party.

PATIENT: **RESPONSIBLE PARTY:**

NIMISH M. PATEL, D.M.D.
6650 GA HWY 85
RIVERDALE, GA 30274
770-997-6222
email: Riverdaledental@gmail.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:

I authorize the professional office of my dentist named above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released: Mostly information for a specialist to see you as a patient: health, diagnostic, and insurance information.
2. To whom may the information be released: To any doctor that the patient has been referred to.

3. The purpose for the release: For treatment by a specialist.

4. Expiration date or event relating to the individual or purpose for the release: At the patient's determination.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Date: Patient Signature:

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: Print Name:

Source of Authority: