DR. ANUSHKA AMIN & ASSOCIATES

REGISTRATION FORM

(Please Print)

Today's date:	Confirmation Method (circle): TEXT EMAIL PHONE

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Email Address:	Birth date: / /	Sex: ❑ M ❑ F

Street address:	Social Security #:	Home phone #: ( )

City:	State:	ZIP Code:	Mobile phone #:	Cell Provider:

Occupation:	Employer:	Employer phone #: ( )

Chose office because/Referred to office by (please check): ❑ Dr. _____ ❑ Location ❑ Friend ❑ Family ❑ Online ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑No

Occupation:	Employer:	Employer phone #: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Delta Dental ❑ Cigna ❑ Metlife ❑ Aetna ❑ Blue Cross Blue Shield ❑ Ameritus ❑ United Concordia ❑ Guardian ❑ Self-pay ❑ other

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group #:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #.: ( )	Mobile phone #.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Anushka Amin or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Continue →

Dental and Medical History

Please fill this form out entirely. This information is important to your dental care!

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

When was your last dental visit?_____ What was done? _____

What is the name of your last dentist? _____

Have you had any unfavorable reactions from dental treatments? _____ If yes, please explain._____

What is the reason for your visit today? _____

Please add anything else you would like us to know about: _____

Signature of patient (or parent) _____ Date _____

Credit Policy

In the interest of good health care practice, it is best to establish a policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end. Therefore, we wish to clarify the following points:

1. All accounts are due and payable at the time of your visit unless satisfactory arrangements have been made with our office manager.
2. We cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim. Insurance reimbursement is a contract between you and your carrier. If payment is not received from your insurance company within 60 days from the date of the claim, you are responsible for payment of your account.
3. It is not our intention to cause you undue hardship, however, we must continue our service to the community.

I have read this Credit Policy and understand that, regardless of any insurance coverage I may have, I am responsible for payment of my account within the usual limits of the Credit Policy (60 days). I agree that in the event costs and/or fees are incurred in connection with the collection of my account, I will pay all such costs and fees. This includes but is not limited to, collection costs, attorney's fees, and all court costs.

Date:_____

X_____

Party responsible for the account

HIPPA Acknowledgement

You may refuse to sign this acknowledgement

I, _____, have read a copy of this office's notice of Privacy Practices.

Please Print Name

_____

Signature

_____

Date

For office use only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited us from obtaining the acknowledgment.
- ☐ An emergency prevented us from obtaining acknowledgment.
- ☐ Other (please specify): _____

Patient Photo Release Form

Patient Name

A. Amin P.C / Dr. Anushka Amin

Provider or Organization name

I hereby authorize the aforementioned Provider or any of their assignees to take photographic, slide, and video images of my teeth, jaws, and face. I understand that the images will be used as a record of my care and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. These images may also be used for advertising purposes (including website publication, Facebook posts, etc.).

I further understand that if these images are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these images. If I wish to revoke this consent, I may do so in writing.

If **declining** to the release of photos in accordance with the terms above, please initial the option below:

_____ I do not agree to the use of my photographs in any of the above stated situations.

If **consenting** to the release of photos in accordance with the terms above, please initial one option:

_____ I agree to the use of my photographs in any of the above stated situations.

_____ I only agree to have my teeth shown without any identifyingfeatures.

Patient Signature _____ Date _____

If individual is unable to sign this Authorization, please complete the information below:

Legal Guardian or Authorized Representative Signature _____ Date _____

Name of Legal Guardian or Authorized Representative

Relationship to Patient