SOUTH FRIENDSWOOD DENTAL ASSOCIATES
SASHA MAHABIR, DDS * RAHUL GANDHI, DMD

www.southfriendswooddental.com
Tel: 281-482-7731

699 S FRIENDSWOOD DR, STE 108
FRIENDSWOOD, TX 77546

PATIENT INFORMATION

Date: .....

☐ NEW PATIENT ☐ UPDATE

Patient: .....
LAST FIRST MI PREFERRED TITLE

☐ MALE ☐ FEMALE ☐ CHILD* ☐ STUDENT** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

.....
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐ FULL-TIME ☐ PART-TIME

.....
SCHOOL/LOCATION

Patient Date of Birth: ..... Patient SSN: .....

Address: .....
ADDRESS LINE 1

.....
ADDRESS LINE 2

.....
CITY ST ZIP CODE

E-Mail: .....

HOME: .....
CELL: .....
OTHER: .....
PAGER: .....
FAX: .....

Referral? ☐ Yes ☐ No Referred by:

MEDICAL HISTORY UPDATES

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐Y ☐N Under a physician's care now?

☐Y ☐N Any hospitalization in the past 5 years? .....

☐Y ☐N Any serious illnesses/surgeries? .....

☐Y ☐N Use tobacco in any form? If Yes, Type: .....

☐Y ☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ☐Y ☐N Currently nursing? ☐Y ☐N Currently pregnant? Due Date: .....

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Y ☐ N
If yes, please describe:

.....

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe:

.....

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ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ACID REFLUX	☐ BULIMIA	☐ HEARING PROBLEMS	☐ PSYCHIATRIC TREATMENT
☐ ADHD	☐ CANCER/MALIGNANCY	☐ HEART ATTACK	☐ RADIATION/CHEMO
☐ AIDS/HIV	☐ CEREBRAL PALSY	☐ HEART DISEASE	☐ RESPIRATORY DISEASE
☐ ANEMIA	☐ CHEMICAL DEPENDENCY	☐ HEART MURMUR	☐ RHEUMATIC FEVER
☐ ANOREXIA	☐ CHICKEN POX	☐ HEPATITIS	☐ SINUS PROBLEMS
☐ ANXIETY	☐ CONVULSIONS	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ ARTIFICIAL HEART VALVE	☐ DEPRESSION	☐ KIDNEY DISEASE	☐ THYROID CONDITION
☐ ARTIFICIAL JOINTS	☐ DIABETES	☐ LIVER PROBLEMS	☐ TUBERCULOSIS
☐ ARTHRITIS	☐ DIZZINESS/FAINTING	☐ MITRAL VALVE PROLAPSE	☐ ULCERS
☐ ASTHMA	☐ EPILEPSY/SEIZURES	☐ MONONUCLEOSIS	☐ VENEREAL DISEASE
☐ AUTISM/ASPERGER'S	☐ FREQUENT EAR INFECTIONS	☐ PACEMAKER	
☐ BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐ OTHER – PLEASE LIST:	

ALLERGIES/ALLERGIC REACTIONS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ ASPIRIN	☐ CODEINE	☐ LACTOSE INTOLERANCE	☐ SLEEPING PILLS	☐ NONE
☐ ANESTHETIC – LOCAL	☐ DAIRY	☐ METAL SENSITIVITY	☐ SULFA DRUGS	
☐ BARBITURATES	☐ LATEX	☐ NITROUS OXIDE SEDATION	☐ PENICILLIN/OTHER ANTIBIOTICS	
☐ OTHER – PLEASE LIST				

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS	☐ ANTIHISTAMINES/ALLERGY	☐ DAILY ASPIRIN	☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS	☐ CANCER/CHEMO MEDICATIONS	☐ CORTISONE/STEROIDS	☐ HEART MEDICATION/DIGITALIS
☐ INSULIN	☐ NITROGLYCERIN	☐ ORAL CONTRACEPTIVES	☐ OSTEOPOROSIS MEDICATIONS
☐ RECREATIONAL DRUGS	☐ THYROID MEDICATIONS	☐ TRANQUILIZERS	☐ OTHER DIABETIC MEDICATIONS
☐ OTC DRUGS/ MEDICATIONS (PLEASE LIST BELOW)	☐ OTHER (PLEASE LIST BELOW)		

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: DATE:

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name: **Date:**

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ GUARDIAN ☐ OTHER(PLEASE EXPLAIN)

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by South Friendswood Dental Associates:

☐ Cell phone: ☐ Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

I give permission for South Friendswood Dental Associates to disclose their identity when calling; to anyone who may answer my phone. ☐Y ☐N ☐ Other (Please explain)

I grant permission for South Friendswood Dental Associates to leave a message on:

☐ Home phone ☐ Work Phone
☐ Cell Phone ☐ With any person who may answer when calling the home or cell phone
☐ None of the above (Please explain)

I would like the following person(s) to have access to my personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

SIGNATURE OF PATIENT/RESPONSIBLE PARTY | NAME OF PATIENT/RESPONSIBLE PARTY (PRINT) | RELATIONSHIP TO PATIENT

DATE

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other – please list:

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PRIMARY INSURANCE

Person Responsible for Account _____
(Last Name) (First Name) (Middle Initial)

Relation to Patient _____ Birthdate _____ Social Security # _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____ ID # _____ Group # _____

ADDITIONAL INSURANCE

Secondary Subscriber _____
(Last Name) (First Name) (Middle Initial)

Relation to Patient _____ Birthdate _____ Social Security # _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____ ID # _____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
(Name of Insurance Company(ies)

and assign directly to Dr. Sasha Mahabir &/or Dr. Rahul Gandhi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor(s) may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Date