Roshan Shroff, D.D.S.PLLC

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If a question has an asterick (*) and does not apply to you please type "NA" or, if it has a check box please select "other".

PATIENT INFORMATION

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* (Last) _____* (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ○ Male ○ Female **Family Status:*** ○ Married ○ Single ○ Child ○ Other

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____* (Address 1) _____ (Address 2)

_____* (City) _____* (State) _____-____* (Zip Code)

The following is for:* ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____* (Last) _____* (First) ___ (MI) _____ (Preferred Name)

What is the reason for your dental visit today? *

_____

_____

Whom may we thank for referring you to our office? *

_____

_____

INSURANCE

PRIMARY INSURANCE

Name of Insured: _____* _____* ___
Last First MI

Insured's Birth Date:* _____ **ID #:*** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name:* _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured:* ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:* _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

SECONDARY INSURANCE

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

PATIENT DENTAL & MEDICAL HISTORY

If you are required to take a Pre-Medication, please indicate what medication you take.

_____

_____

Please indicate if you have experienced any of the following:

☐ Pre Med	☐ AIDS/HIV+	☐ Anaphylaxis
☐ Anemia	☐ Arthritis (Rheumatism)	☐ Artificial Heart Valves
☐ Artificial Joints	☐ Asthma	☐ Atopic (Allergy Prone)
☐ Back Problems	☐ Blood Disease	☐ Cancer
☐ Chemical Dependency	☐ Circulatory Problems	☐ Cortisone Treatments
☐ Cough (Presistent)	☐ Cough Up Blood	☐ COVID-19
☐ COVID-19 VACCINE (1st injection)	☐ COVID-19 VACCINE (2nd injection)	☐ COVID-19 BOOSTER
☐ Diabetes	☐ Epilepsy	☐ Fainting
☐ Food Allergies	☐ Glaucoma	☐ Headaches
☐ Heart Murmur	☐ Heart Problems	☐ Hemophilia
☐ Herpes	☐ Hepatitis A	☐ Hepatitis B
☐ Hepatitis C	☐ High Blood Pressure	☐ Jaw Pain
☐ Kidney Disease	☐ Liver Disease	☐ Mitral Valve Prolapse
☐ Nervous Problems	☐ Pacemaker/Heart Surgery	☐ Psychiatric Care
☐ Rapid Weight Gain/Loss	☐ Radiation Treatment	☐ Respiratory Disease
☐ Rheumatic/Scarlet Fever	☐ Shingles	☐ Shortness of Breath
☐ Skin Rash	☐ Spina Bifida	☐ Stroke
☐ Surgical Implant	☐ Swelling of Feet or Ankles	☐ Thyroid Disease
☐ Tobacco Habit	☐ Tonsillitis	☐ Tuberculosis
☐ Ulcer/Colitis	☐ Venereal Disease	☐ Other

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

☐ Aspirin	☐ Nitrous Oxide	☐ Local Anesthetic
☐ Codeine	☐ Erythromycin	☐ Penicillin
☐ Latex	☐ Sulfa	☐ Other_____

Please explain if you have checked any of the above boxes:

_____

_____

_____

Please list any medications you are currently taking, one medication per line:

WOMEN ONLY: Are you pregnant? ○ Yes ○ No

If Yes, when is the due date? _____

Would you consider yourself to be in fairly good health? ○ Yes ○ No

Within the past year, have there been any changes in your general health? ○ Yes ○ No

When is the last time you visited a dentist? *

Prior Dentist's name

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2 - 6 weekly ○ 1 - 6 monthly ○ Seldom ○ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?
☐ Do your teeth experience sensitivity to hot or cold temperatures?
☐ Are any of your teeth currently causing you pain?
☐ Do you grind your teeth (either consciously or during sleep)?
☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
☐ Do you currently have any dental implants, dentures and/or a partial(s)?

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ * **CANCELLATION/NO SHOW POLICY**

I will give Shroff Dental Arts a minimum of 24 business hours notice to cancel or reschedule any dental appointments. Failure to give such notice can result in a $50.00/hour fee for my missed appointment. I have read and understood this policy.

☐ * **COMMUNICATIONS**

I authorize Shroff Dental Arts to correspond with me regarding appointments, financials, etc... through text, phone calls, email and/or US Mail. I understand that my phone carrier may apply finance charges and that will be my responsibility.

Cell Phone Number *

FINANCIAL POLICY

☐ *

Thank you for choosing Dr. Roshan Shroff for your dental care needs. The following information will explain our procedures and policies, which have been established so that we may serve you as promptly and efficiently as possible. Financial arrangements must be made prior to treatment.

*** Payment is due in full at the time of service.**
*** We accept cash, checks, Visa, American Express, MasterCard, and Discover cards**
*** Patients with insurance coverage are responsible for any deductibles and estimated co-payment at the time of service.**
*** Third party financing is available for patients requiring extensive treatment.**

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

As a service to our patients we will bill your insurance company. However, your insurance policy is a contract between you and your insurance company. Insurance policies vary and services provided may not be covered. You are responsible for any fees insurance does not pay. Recently, we have noticed that patients with dual coverage, in some cases, the secondary insurance company will not pick up any or all of the remaining balance. Please refer to your employee manual for specific coverage explanations.

I understand and agree to abide by this Financial Policy and understand that I am responsible and agree to pay any collection, court and attorney fees accrued.

☐ * **AUTHORIZATION**

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

Patient Name *

PATIENT/PARENT/GUARDIAN SIGNATURE

Signature _____ **Date** _____

Parent/Guardian PRINTED Name

Response Date: _____