Welcome

Welcome to Joshi Dental, LLC. Please take a few moments to fill out the following forms and remember to sign at the X's. If you have any questions, we will be happy to help you. Your privacy is very important to us. Please be assured that all information will be kept in the strictest of confidence. Thank you for placing your trust in us.

Patient Information:

Name: _____, _____ _____ Date: _____/_____/_____
Last Name First Name Initial mo day yr

Home Address: _____
Street City State Zip

Home Phone: (_____) _____ Social Security Number: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M / F

Driver's License #: _____ Marital Status: _____

Cell Phone #: _____ Email Address: _____

Patient's Employer: _____ Occupation: _____

Business Address: _____
Street City State Zip

Business Phone: (_____) _____ext:_____

Spouse's Name: _____

Spouse's Occupation: _____ Spouse's Social Security Number: _____

Whom should we thank for referring you to our office? _____

Name and number of person to contact in case of emergency: _____

Insurance Information:

Primary Insurance:

Person Responsible for Account: _____

Relationship to Patient: _____ Insured Person's Date of Birth: ___/____/____

If different from above:

Address: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Social Security Number of Responsible Party: _____

Insurance Company: _____ Policy or Group Number: _____

Please turn over to complete other side⇒

Secondary Insurance:

Person Responsible for Account: _____

Relationship to Patient: _____ Insured Person's Date of Birth: ____/____/____

If different from above:

Address: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Social Security Number of Responsible Party: _____

Insurance Company: _____ Policy or Group Number:_____

Email Communication Consent:

I consent / do not consent (please circle one) to receive email communications regarding treatment, insurance, special promotions and my account from Joshi Dental. I understand that I can withdraw my consent at any time.

Insurance and Treatment Authorization:

I understand confidential information may be shared my insurance company in order to process claims. I have the right to limit, upon request, how this information shall be used and with whom it will be shared.

I authorize my insurance company to pay to Joshi Dental, LLC all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the release of all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize and give my consent to any advisable and necessary dental procedures, medications, and/or anesthetics to be administered by the staff of Joshi Dental, LLC for diagnostic purposes or dental treatment.

X_____ Date: _____

(If under 18 years of age, signature of parent or guardian)

Medical History:

Physician's Name: _____ Physician's Phone Number: _____
Physician's Address: _____
Date of last medical check-up: _____
Have you had any major illnesses or operations? Y / N Describe: _____
Have you ever been hospitalized? Y / N Describe: _____
List any medications you are currently taking: _____
List any allergies to medications: _____
Have you ever taken medication for weight loss? Y / N List: _____
Women: Are you pregnant? Y / N If yes, due date: _____
Are you nursing? Y / N Are you using oral contraceptives? Y / N
Check box if you have now or have ever had the following:

- ☐ **AIDS/HIV**
- ☐ **Anemia/Blood Disease**
- ☐ **Arthritis (Rheumatic)**
- ☐ **Artificial Heart Valves**
- ☐ **Artificial Joints/Joint Surgery**
- ☐ **Asthma/Breathing Difficulty**
- ☐ **Bleeding/Clotting Problems**
- ☐ **Blood Transfusion**
- ☐ **Cancer/Chemotherapy**
- ☐ **Chemical Dependency**
- ☐ **Cortisone Treatments**
- ☐ **Cough - Persistent**
- ☐ **Diabetes**
- ☐ **Epilepsy/Seizures**
- ☐ **Fainting/Dizziness**
- ☐ **Glaucoma**
- ☐ **Frequent Headaches**
- ☐ **Heart Murmur**
- ☐ **Heart Problems**
- ☐ **Hepatitis**
- ☐ **High or Low Blood Pressure**
- ☐ **Jaw Pain**
- ☐ **Kidney Disease/Dialysis**
- ☐ **Liver Disease/Jaundice**
- ☐ **Lupus**
- ☐ **Mitral Valve Prolapse**
- ☐ **Neurological Problem**
- ☐ **Nervous or Mental Disorder**
- ☐ **Pacemaker**
- ☐ **Radiation Treatment**
- ☐ **Rheumatic Fever**
- ☐ **Swelling of Feet or Ankles**
- ☐ **Swollen Glands**
- ☐ **Thyroid Problems**
- ☐ **Tobacco Use/Smoking**
- ☐ **Tuberculosis**
- ☐ **Venereal Disease**
- ☐ **Unexplained Weight Loss**

If you answered yes to any of the above, please describe: _____
Please give any other information you may consider important: _____

Dental History:

Reason for today's visit: _____
Previous Dentist: _____ Date of Last Dental Visit: _____
Date of Last Checkup and Cleaning: _____ How often do you brush? _____ floss?_____
Check box if you have now or have ever had the following:

- ☐ **Bad Breath**
- ☐ **Bleeding or Swollen Gums**
- ☐ **Dry Mouth**
- ☐ **Burning Sensation in Tongue**
- ☐ **Lumps or Bumps in Mouth or Tongue**
- ☐ **Mouth or Lip Blisters**
- ☐ **Food Collecting Between Teeth**
- ☐ **Clicking or Popping Jaw**
- ☐ **Grinding or Clenching Teeth**
- ☐ **Jaw or Facial Muscle Pain**
- ☐ **Lip or Cheek Biting**
- ☐ **Loose Teeth or Fillings**
- ☐ **Broken Teeth or Fillings**
- ☐ **Sensitive or Painful Teeth**
- ☐ **Complications from Dental Treatment or Extractions**
- ☐ **Dental Implants**
- ☐ **Injuries to Mouth or Jaw**
- ☐ **Periodontal Treatment (Gum Surgery)**
- ☐ **Scaling / Root Planing**
- ☐ **Orthodontic Treatment**
- ☐ **Root Canals**
- ☐ **Dentures**
- ☐ **Extractions**

Are you happy with the appearance of your teeth? Y/ N_____
Are you interested in any new cosmetic procedures such as bleaching, bonding, or veneers to help you whiten or straighten your teeth? Y / N_____
To the best of my knowledge, the above information is correct:

X_____ Date: _____
(If under 18 years of age, signature of parent or guardian) BP: _____/_____ Arm: ____ Pulse: _____ Date: _____