



Parmar Cosmetic & Family Dentistry
 Rashmi K. Parmar, D.M.D, P.C,
 12620 Clarksville Pike (RT108)
 Clarksville. MD 20129

PH : 410-531-5639
 Fax : 410-531-6625
 Email : office@weststyleyoursmile.com

1. PATIENT INFORMATION

Date _____
 Social Security # _____
 Patient Name _____
Legal Name

Wish to be called _____
 Partnered for ____ years
 Responsible Party _____
Name/Relationship

Address _____
 City _____
 State _____ Zip _____
 Sex M F
 Birth date _____ Age _____
 Married Widowed Single
 Minor Separated Divorced
 Patient Employer / School _____
 Occupation _____
 Employer /School Address _____

 Employer / School Phone (_____) _____
 Spouse's Name _____
 Spouse's Birth Date _____
 Spouse's Social Security # _____
 Spouse's Employer _____
 How did you hear about our office?

2. INSURANCE INFORMATION

Subscriber's Name _____
 Subscriber's Birth Date _____
 Subscriber's ID or SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Phone # _____
 Is there any additional dental insurance
Yes No

Subscriber's Name _____
 Subscriber's Birth Date _____
 Subscriber's ID or SS# _____
 Relationship to Patient _____
 Insurance Co _____
 Phone # _____
 Is there additional dental insurance
Yes No

Subscriber's Name _____
 Subscriber's Birth date _____
 Subscriber's SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Phone # _____

ASSIGNMENT AND RELEASE
 I understand that Dr. Parmar does not participate with many insurance companies and that reimbursements will come to me directly from the insurance company.
 The above named dentist may use my healthcare

 Signature of Patient, Parent, Guardian or Personal Representative

 Date

 Relationship to Patient

3. CONTACT INFORMATION

Home (_____) _____ Cell Phone (_____) _____
 Work (_____) _____ Ext _____
In Case of Emergency
 Name _____ Relationship _____
 Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Used for Confirming Appointments

Used for Confirming Appointments



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4. DENTAL HISTORY

Fear, Trust, Time, Money, Ungency

D I S C

Date of last Dental Visit _____

Reason for today's visit _____

How Healthy do you want us to get your mouth

- Don't really care Average The best it can be

Are you happy with the appearance of your teeth/smile/face? _____

Does your mouth function properly? Yes No

If no, how does it not function properly? _____

Should you need treatment at what point should we address it?

- When tooth hurts or Breaks When something worsens When something isn't ideal

Are you fearful? Yes No Rate your fear level 1-10 _____

Did you have any bad experience or reason for the fear? Explain _____

We have ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you (Please Circle)

- As a General dentist As a Cosmetic dentist As a Functional dentist

What quality of dentistry do you want us to recommend

- Just Patch It Average Deal/Best

Did you have financial concerns? Yes No

What are your financial concerns? _____

Special time frames? _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Clenching teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting/Thumbsucking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaws pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ringling in the ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sensitivity to biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sensitivity to hot, cold, sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vertigo /Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tingling in arms/fingers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No		



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5. HEALTH HISTORY

Physician's Name _____ Phone # _____ Date of Last Full Physical _____

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
ANEMIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head/neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight _____ Lbs.	
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Height _____ ft. ____ In	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infective Endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you use tobacco products?
 Yes No If yes, what and how often, how long _____

Do you use antidepressants or sleeping pills?
 Yes No If yes, list name(s) _____

Sleep Apnea Yes No (C Pap) Yes No Have you had sleep Studies Yes No
 Do you Snore Yes No Have you seen ENT Yes No
 Are you on any blood thinners, including Aspirin? Yes No mg _____ No Have you seen neurologist Yes No
 Have you seen chiropractor Yes No

Are you currently taking or have taken any of the following medications?
 Alendromate-Fosomax-oral Yes No
 Clodronate-Ostac, Bonafos-IV and oral Yes No
 Etidronate-Didronal-IV and oral Yes No
 Ibandrote-Boniva-oral Yes No
 Pamidronate-Aredia -IV Yes No
 Risedronate-Actonel-oral Yes No
 Tiludronate-Skelid-oral Yes No
 Zoledronic acid- Zometa -IV

WOMEN:

Are you pregnant
 Yes No If yes, when is your due date? _____
 Taking birth control pills? Yes No
 Are you taking hormones? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis _____

Vitamins / Minerals Herbs

Pharmacy Name _____

Phone (____) _____

Aspirin Local Anesthetic
 Barbiturates (sleeping pills) Pencillin
 Codeine Sulfa
 Lodine Other _____
 Latex
 None _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge

Patient Signature _____ Date _____



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6. CONSENT AND RELEASES

Please **INITIAL** and **SIGN** below.

I hereby authorize Dr. RASHMI PARMAR and/or her staff to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care and treatment, and hereby authorize their use for educational purposes in future lectures, and demonstrations by Dr. PARMAR and/or her staff.

I hereby give my permission to have my testimonials and/or photos, slides, and videos utilized by Dr. PARMAR and/or her staff for professional marketing to help other patients understand the benefits of the services rendered by this office. I further understand I will receive no further financial compensation for the use, at anytime in the future, of my testimonials, photos, slides, or videos by Dr. PARMAR and her staff.

I hereby give a limited duration of health care power of attorney to (name) _____ of (address) _____ and (phone) _____ my (relationship) _____ and by so doing, I hereby give my permission and consent for them to make treatment decision(s). Including surgery and medication, on my behalf during my sedation visit(s). I hereby ratify and confirm all that my attorney shall do or cause to be done by virtue of this health care power of attorney and the rights and powers granted herein. Upon conclusion of my sedation treatment with Dr. Parmar then this health care power of attorney shall be considered revoked.

I understand that responsibility for payment for dental services provided by this office for myself or my dependent is solely mine, with full payment due and payable before the time of services rendered. In the event of default in any payment, I promise to pay the legal interest rate on such indebtedness until fully paid together with all collection cost (s) including non sufficient fund fees, court costs, and reasonable attorney's fees that may be required to effect full collection of this note and any balance due hereunder, whether or not formal litigations is instituted.

We do not render our services on the basis that the Insurance Company will pay all our fees. Most Insurance companies pay only a portion of the dental investment. We are happy to file the necessary forms to see that you receive full benefits of your coverage, however, we make no guarantee of any estimated dis coverage. We will file primary Insurance. Patients are responsible for filing any secondary insurance coverage they may have.

You must provide us with **48 business hours** advance notice for any cancellations of any of your appointments in order to avoid in order to avoid the imposition of cancellation fees, which are determined by the length and type of services being rendered at the scheduled visit. Such cancellation fees are **non-refundable**.

I have read and understood this entire agreement before signing here below, and i have endorsed this agreement voluntarily, without duress, and of my own free will and choice, and I received a copy of RECORD TRANSFERS; In case of the need to transfer patient record, we require 5 working days to duplicate the records. A reasonable record duplication and transfer charge will be collected prior to any record transfer.

Patient or Responsible Party _____ Date _____



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private 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 operation I also understand you are not required to agree to my request restriction, but if you do agree then you are bound to abide by such restriction.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICIAL USE ONLY

I attempt to obtain the patients signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented Below:

Date :	Initials:	Reason:
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