Date: _____

Patient Information

Name (Last, First): _____ **Date of Birth:** _____

Street Address: _____ **Social Security #:** _____

City State Zip: _____ **Home Phone:** _____

E-Mail Address: _____ **2nd Phone:** _____

Sex: Male☐ Female ☐ **Marital Status**: Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐

Employer/School Name: _____ **Occupation** _____

Employer Address: _____ **Phone #:**

City State Zip:

Spouse Information

Name (Last, First): _____ **Date of Birth:** _____

Employer Name: _____ **Social Security #:** _____

City State Zip: _____ **Phone #:** _____

Dental Insurance Information (Primary)

Insurance Name: _____ **Address:** _____

ID#: _____ **Group #:** _____ **Plan Name or #:** _____

Name of Insured: _____ **Date of Birth:** _____ **Social Security #:** _____

Insured's Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other☐

Dental Insurance Information (Secondary)

Insurance Name: _____ **Address:** _____

ID#: _____ **Group #:** _____ **Plan Name or #:** _____

Name of Insured: _____ **Date of Birth:** _____ **Social Security #:** _____

Insured's Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other☐

Emergency Information (Specify someone who does not live in your household)

Contact Name: _____ **Relationship:** _____ **Phone:** _____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with (state name of insurance company(ies) _____ and assign directly to Dr. Shikha Batra 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 dentist 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 of the benefits payable for related services.

_____	_____	_____	_____
Signature of Patient, Parent or Guardian	**Please print name of Patient, Parent or Guardian**	**Relationship**	**Date**

Top of Troy Dental **755 W Big Beaver Rd, Suite # 415 ◆ Troy ◆ MI ◆ 48084-4903**

Date: _____

Dental History

Reason for today's visit? _____

Former Dentist: _____ **City/State:** _____

Date of last dental visit _____ **Date of last dental x-rays:** _____

Please select "yes" or "no" to indicate if you have/ had any of the fol owing:

1. Bad breath?	Yes ☐	No ☐
2. Bleeding gums?	Yes ☐	No ☐
3. Blisters on lips or mouth?	Yes ☐	No ☐
4. Chew on one side of month?	Yes ☐	No ☐
5. Cigarette, pipe or cigar smoking?	Yes ☐	No ☐
6. Clicking or popping jaw?	Yes ☐	No ☐
7. Dry mouth?	Yes ☐	No ☐
8. Fingernail biting?	Yes ☐	No ☐
9. Food collection between the teeth?	Yes ☐	No ☐
10. Grinding of teeth?	Yes ☐	No ☐
11. Gums swollen or tender?	Yes ☐	No ☐
12. Jaw pain or discomfort?	Yes ☐	No ☐
13. Loose teeth or broken filling?	Yes ☐	No ☐
14. Mouth breathing?	Yes ☐	No ☐
15. History of orthodontic treatment?	Yes ☐	No ☐
16. History of root canal treatment?	Yes ☐	No ☐
17. History of periodontal treatment?	Yes ☐	No ☐
18. Sensitivity to cold, hot, sweets, biting?	Yes ☐	No ☐
19. Are you happy with your smile?	Yes ☐	No ☐
20. How often do you brush?	Yes ☐	No ☐
21. Is there anything you would like to change about your smile?	Yes ☐	No ☐
22. Have you ever had cosmetic dentistry?	Yes ☐	No ☐
23. Have you ever had botox treatments?	Yes ☐	No ☐
24. Have you ever had juvederm treatments?	Yes ☐	No ☐
25. Have you ever had botox treatments?	Yes ☐	No ☐
26. Have you ever had dermal fillers?	Yes ☐	No ☐

Signature _____ **Date** _____

Shikha Batra, D.M.D.
755 West Big Beaver
Suite 415
Troy, MI 48084
248-362-1100
topoftroydental@comcast.net

Dear Patient,

We are committed to providing you with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. Our hope is that any misunderstandings can be avoided.

Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor for payment of services. Due to constantly changing insurance contracts, benefits and deductibles, we are only able to approximate your insurance coverage. As a courtesy to you, we will file your insurance claim at no additional charge. If the insurance company pays less than expected, you will be charged the difference. If we haven't received payment from your insurance carrier after 90 days, we will charge the balance back to you. Final responsibility for payment rests with the person responsible for your account. (Patients who accompany minor children are responsible for the charges incurred.) If you have concerns about the insurance reimbursement, it is your responsibility to contact your insurance carrier to resolve the problem.

Payment for co-payments or other charges are due at the time of service. We accept Visa and MasterCard. For you convenience, our office has made arrangements with the dental credit card, Care Credit. We are proud to be able to offer lower monthly payments with an interest free period to our valued patients who qualify for credit. If interested, please ask for details.

If for any reason you request a records or x-ray transfer, an administrative fee will be charged.

If your insurance company does not pay in full within 60 days, we may ask you to pay your balance with cash, check or credit card. A fee of $25 will be assessed on returned checks.

If credit is extended for any reason, I authorize your office to obtain my credit report.

I understand that treatment fees quoted are honored for up to a three month time period and may change after that.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask. We are here to help you.

Dr. Shikha Batra & Staff

_____

Patient Signature & Date

HEALTH HISTORY

Patient Name: _____ **Patient Identification #:** _____ **Date of Birth:** _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?
4. Yes No Are you being treated by a physician now? For what?
   Date of last medical exam? Date of last Dental exam?
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, medications, latex?	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	50.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	No	Alcohol?

Please list:

VI. WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Are you taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ **Date:** _____

Shikha Batra, D.M.D.
755 West Big Beaver
Suite 415
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Dr. Shikha Batra & Staff

_____

Patient Signature & Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/01/2005, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.99 for each page, $50.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Shika Batra

Telephone: 248-362-1100 Fax: 248-362-2324

E-mail: info@topoftroydental.com

Address: 755 W. Big Beaver Rd, Suite # 415, Troy, MI 48084-4903