advancedental

N. Nathan Nagavi, DDS
13350 Josey Ln. Suite A,
Farmers Branch, TX 75234

Office (972) 241-1934
Fax (972) 481-1906

1 Patient Registration

Patient Name					
Patient Number	Sex O M O F	Date of Birth	Age	Today's Date	
Home Address		City	State	Zip Code	
Please Check One O Single O Married O Separated O Widowed		Occupation		Are You a Full-Time Student? O Yes O No	
E-Mail Address		Mobile Phone Number	Home Phone Number		
Employer	Length of Employment	Social Security Number	Work Phone Number		

Name of Person Responsible for Account		Driver's License Number
Name of Spouse (Parent if Patient is a Minor)	E-Mail Address	Mobile Phone Number
Spouse's (Parent's) Employer	Spouse's Social Security Number	Work Phone Number

How Did You Hear About Our Office?	**EMERGENCY CONTACT** Name, Address & Telephone Number of a Relative NOT Living With You.
Reason For This Visit	

2 Dental Insurance Information

Name of Insured	**Date of Birth**	**Social Security Number**
Name of Employer		
Insurance Company		
Address		
Phone Number	**Group Number**	**Local Number**

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3 Dental History

Please check any of the following problems that apply to you.

o Sensitivity (hot, cold, sweet)
Where? o Upper Right o Lower Right o Upper Left o Lower Left

o Headaches, earaches, neck pain
o Jaw joint pain
o Teeth or fillings breaking
o Grinding or clenching teeth
o Bleeding, swollen or irritated gums
o Loose, tipped or shifting teeth
o Bad breath

Do you have or have you had any of the following?

o Dentures
o Partial dentures
o Braces
o Periodontal (gum) treatments
o Wisdom teeth removal?

Please share the following dates:

Your last cleaning _____ / _____
Your last oral cancer screening _____ / _____
Your last complete X-Rays _____ / _____

Name of Previous Dentist _____

_____
City State

_____
Phone Number

What is the most important thing to you about your future smile and dental health?

_____
_____
_____
_____

If you could whiten your teeth for a cost anyone could afford, would you do it? o Yes o No

Do you smoke or use chewing tobacco?

How Much? _____ How Long? _____

If I could change my smile, I would:

o Make them whiter
o Make them straighter
o Close spaces
o Replace black metal fillings with tooth colored restorations
o Repair chipped teeth
o Repair missing teeth
o Replace old crowns that don't match
o Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____
_____

What is the most important thing to you about your dental visit today?

_____
_____
_____
_____

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4 Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, Visa, MasterCard and Discover. Outside financing is available upon request and approval.

o **Please check if you would like more information about financing options.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company by cash, check, Visa, MasterCard or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or if your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our Financial Policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Signature of Patient or Guardian

Date