Verma Dental

Stress less. Smile often. Sleep well.

702 W. Centerville Rd. Ste. 100 Garland Tx. 75041
P/ 972.279.9494
F/ 972.270.9126

NEW PATIENT REGISTRATION

Today's Date: _____

Patient Name: _____ Date of Birth _____
Preferred Name: _____
Patient/Parent Social Security Number _____-____-_____
Drivers License Number _____ State: _____
Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor
Address _____City: _____State:_____
Home: (_____) _____ Cell: (_____) _____ Work: (____) _____
Email Address: _____@_____

Primary Care Physician (PCP) Name: _____ **Phone:** _____
Pharmacy Name: _____ **Phone:** _____
Emergency Contact: _____ **Relationship to patient:** _____
Phone # of Emergency Contact: _____

What do you do for a living: _____
Whom May We Thank For This Referral? _____

Method of Payment:
❑ Insurance ❑ Credit Card ❑ Cash ❑ In Office Discount Plan
Dental Insurance: (leave blank if you have already provided dental insurance upon scheduling)
Policy Holder Name: _____
Policy Holder Date of Birth: _____ _____
Employer: _____ _____
Relationship to policy holder: _____
Name of Insurance Co. _____
Policy Number _____Group Number _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❑ Yes ❑ No If yes, please explain:

_____

Have you ever been hospitalized or had a major operation ❑ Yes ❑ No If yes, please explain:

_____

Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes, please explain:

_____

Are you taking any medications, pills, or drugs? ❑ Yes ❑ No

If yes, please list medication name and dosage: _____

_____

Are you taking any king of blood thinners such as any product containing aspirin, any natural herbs, vitamin E or fish oil supplements or CBD oil? ❑ Yes ❑ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ❑ Yes ❑ No

Have you ever taken?

Fosamax ❑ Yes ❑ No

Boniva ❑ Yes ❑ No

Actonel ❑ Yes ❑ No

Any medications containing bisphosphonates? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Do you use controlled substances? ❑ Yes ❑ No

Women: Are you Pregnant/Trying to get pregnant? ❑ Yes ❑ No

Women: Are you taking oral contraceptives? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Acrylic ❑ Metal ❑ Latex ❑ Sulfa drugs ❑ Other: _____

Do you have, or have you had, any of the following? Please check Yes or No:

❑ Yes ❑ No AIDS/HIV Positive
❑ Yes ❑ No Anaphylaxis
❑ Yes ❑ No Anemia
❑ Yes ❑ No Angina
❑ Yes ❑ No Arthritis/Gout
❑ Yes ❑ No Artificial Heart Valve
❑ Yes ❑ No Artificial Joint
❑ Yes ❑ No Asthma
❑ Yes ❑ No Blood Disease
❑ Yes ❑ No Blood Transfusion
❑ Yes ❑ No Breathing Problem
❑ Yes ❑ No Irregular Heartbeat
❑ Yes ❑ No Heart Pacemaker
❑ Yes ❑ No Heart Trouble/Disease
❑ Yes ❑ No Heart Transplant
❑ Yes ❑ No Congenital Heart Disease
❑ Yes ❑ No Endocarditis
❑ Yes ❑ No Hepatitis A
❑ Yes ❑No Hepatitis B or C
❑ Yes ❑ No High Blood Pressure
❑ Yes ❑ No High Cholesterol
❑ Yes ❑ No Hives or Rash
❑ Yes ❑ No Hypoglycemia
❑ Yes ❑ No Easily Winded
❑ Yes ❑ No Kidney Problems
❑ Yes ❑ No Leukemia
❑ Yes ❑ No Liver Disease

❑ Yes ❑ No Alzheimer's disease
❑ Yes ❑ No Bruise Easily
❑ Yes ❑ No Cancer if yes: _____
❑ Yes ❑ No Chemotherapy
❑ Yes ❑ No Chest Pains
❑ Yes ❑ No Cold Sores/Fever Blisters
❑ Yes ❑ No Congenital Heart Disorder
❑ Yes ❑ No Convulsions
❑ Yes ❑ No Cortisone Medicine
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Drug Addiction
❑ Yes ❑ No Emphysema
❑ Yes ❑ No Low Blood Pressure
❑ Yes ❑ Hemophilia
❑ Yes ❑ No Sinus Trouble
❑ Yes ❑ No Mitral Valve Prolapsed
❑ Yes ❑ No Osteoporosis
❑ Yes ❑ No Pain in Jaw Joints
❑ Yes ❑ No Parathyroid Disease
❑ Yes ❑ No Psychiatric Care
❑ Yes ❑ No Radiation Treatments
❑ Yes ❑ No Recent Weight Loss
❑ Yes ❑ No Renal Dialysis
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Rheumatism
❑ Yes ❑ No Scarlet Fever
❑ Yes ❑ No Shingles

❑ Yes ❑ No Epilepsy or Seizures
❑ Yes ❑ No Excessive Bleeding
❑ Yes ❑ No Excessive Thirst
❑ Yes ❑ No Fainting Spells/Dizziness
❑ Yes ❑ No Frequent Cough
❑ Yes ❑ No Frequent Diarrhea
❑ Yes ❑ No Frequent Headaches
❑ Yes ❑ No Genital Herpes
❑ Yes ❑ No Glaucoma
❑ Yes ❑ No Hay Fever
❑ Yes ❑ No Heart Attack/Failure
❑ Yes ❑ No Heart Murmur
❑ Yes ❑ No Sickle Cell Disease
❑ Yes ❑ No Lung Disease
❑ Yes ❑ No Herpes
❑ Yes ❑ No Spinal Bifida
❑ Yes ❑ No Stomach/intestinal Disease
❑ Yes ❑ No Swelling of Limbs
❑ Yes ❑ No Thyroid Disease
❑ Yes ❑ No Tonsillitis
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Tumors or Growths
❑ Yes ❑ No Ulcers
❑ Yes ❑ No Venereal Disease
❑ Yes ❑ No Yellow Jaundice

Have you ever had any serious illness not listed above?

❑ Yes ❑ No If yes, please explain _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

STOP-BANG
Sleeping Disorder Questionnaire

S (snore)	Do you SNORE?	Yes	No
T (tired)	Do you often feel TIRED or sleepy during the daytime?	Yes	No
O (observed)	Has anyone OBSERVED you stop breathing during your sleep (even once)?	Yes	No
P (pressure)	Do you have or are you being treated for high blood PRESSURE?	Yes	No

B (bmi)	Is your Body Mass Index (BMI) more than 35?	Yes	No
A (age)	Is your AGE over 50 years old?	Yes	No
N (neck)	Is your NECK circumference 16 inches or greater?	Yes	No
G (gender)	Is your GENDER male?	Yes	No

Weight: _____
Height: _____
BMI: _____
Neck Size: _____

Staff Section Only:
Family Health History:

_____
_____
_____

RADIOGRAPHIC (X-RAYS) & CLINICAL EXAMINATION CONSENT

PATIENT NAME: _____ DOB: _____

DENTAL PROVIDER: DEEPALI VERMA, D.D.S.

I give the team at **Verma Dental** permission to perform the following in order to get a complete dental health assessment.

- **Radiographs (x-rays)**
- **Photographs of teeth**
- **Periodontal Measurements**
- **Charting of Existing Restorations**
- **Diagnostic Cast (models of teeth)**
- **Bite Records**

Furthermore, I authorize **Dr. Verma** to conduct a complete exam of the dental condition included but not limited to

- **American Cancer Society Head/Neck (intraoral/ extra oral) cancer screening**
- **TMJ evaluation**
- **Sleep Apnea Evaluation**
- **Periodontal Evaluation**
- **Complete Inventory of Existing Restorations**
- **Radiographic Evaluation of Oral / Head/Neck Structures as Needed**
- **Evaluation of Occlusion of Teeth**
- **The Development of Personalized life-long Plan for Dental Health**

Patient/ Guardian Printed Name: _____

Patient / Guardian Signature: _____ **Date:** _____

Witness/ Staff Signature: _____ **Date:** _____

Limited Dental Warranty

Our Practice is proud of the dentistry that we provide for you and your family. Our goal is to not just correct any dental problems you may have, but to also show you how to prevent dental disease in the future, saving you both time and unnecessary expense.

We will warranty dental crowns, bridges and veneers. If your crown, bridge or veneer need replacement, and the tooth is still savable and if you kept your visits up to date as recommended by Dr. Verma we will:

- Replace the crown with a new crown of the same type
- Replace the porcelain veneer with a new one
- Replace the bridge with a new bridge of the same type

Warranty for the first three years is at no charge. For the fourth year and forward a fee of 50% of the cost of the crown, bridge or veneer cost will apply.

This warranty does not cover accidents that caused damage to the teeth. All services must be performed at Verma Dental located at 702 W. Centerville Rd. Ste. 100, Garland, Tx. 75041 in order to be considered valid. You also must complete (in our office) all recommended dental treatment in the quadrant (the section of the mouth in which the tooth is located) and adjunct procedures such as nightguards if recommended. This also includes keeping recommended appointments with our hygienist, and yearly exams by Dr. Verma, as well as x-ray frequency. Your path to optimal health requires a comprehensive approach to care.

***This warranty is null and void if the patient does not maintain his/her regular cleaning and check-up appointment every 3, 4, or 6 months as recommended by Dr. Deepali Verma or the hygienist.

Patient Name: (please print): _____

Patient Signature: _____ Date: _____

Staff Witness Signature: _____ Title: _____

Oral Cancer Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We have recently incorporated ViziLite* Plus into our oral screening standard of care this state-of-the-art technology will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Oral cancer risk by patient profile is as follows:

Who is at Risk?

- **Age - 17+ years**
- **Tobacco Use**
- **Alcohol Use**
- **HPV infection**
- **Previous History of Cancer**

We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as **CDT-5** procedure code **D0431**; however, this exam is not covered by the majority of dental insurance plans. The fee for this enhanced examination is **$25.**

_____**Yes**, I authorize Verma Dental clinicians to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

_____ **No,** I would prefer not to have the ViziLite Plus exam at this time.

Print Name: _____

Patient Signature: _____ Date: _____

Photo Consent

I recognize that my dentist and dental team are proud of the quality treatment that they will provide to me. I, hereby, provide my consent for dental photographs, videos or audio to be taken of me and/or my dependent(s) for dental treatment. I understand that my dental images maybe used for various educational and marketing purposes. By consenting to release my dental photographs, videos or audio, I understand that I will not receive payment from any party. Although these materials will be used without identifying information, I understand that it is possible that someone may recognize me. Refusal to consent to dental photographs or videos or audio will in no way affect the dental care that I will receive.

I authorize the use of my images (Please circle YES or NO)

YES **NO** For professional journal(s) or publications, lectures, seminars, and demonstrations.

YES **NO** For the office website and social media such as: Facebook, Instagram, Twitter, etc.

YES **NO** As non-identifying photos only

Patient Signature : _____ **Patient Name :** _____ **Date :** _____

Patient E-mail & Text Messaging Consent

Due to the changing world of healthcare and technology, we now have the ability to provide our patients with certain types of information via e-mail and or text messaging. We believe strongly the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from us via email or text messaging. We do not share names, email address, and or telephone numbers of patients with any other companies, or with any other patient. By placing my signature below, I acknowledge that I have read and understand the above statement on emails and text messages. I hereby give permission to Verma Dental to send me via the selection(s) indicated below means of communication. Should I have any questions, I can contact the practice at any time.

- ☐ **Email and Text**
- ☐ **Email Only**
- ☐ **Text Only**
- ☐ **NONE**

Patient Signature : _____ **Patient Name :** _____ **Date :** _____

Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. Many offices double book appointments to prevent from being financially damaged as a result of missed appointments. However, it does not allow us to give the care and attention needed to provide excellent quality dentistry and for this reason we have chosen not to do it.

Please notify Verma Dental if you are unable to keep your appointment. We have reserved this time period just for YOU and YOUR dental care! We ask that you please be considerate and give us at least 48 hours' notice if you plan to cancel or reschedule your appointment. (If you contact us during a day, we are not open you may leave us a voicemail) If you do so, there will be no action taken for a cancellation charge. This amount of notice allows us to easily reschedule your appointment as well as assist another patient in utilizing your cancelled time period.

Our policy is as follows:
There will be a charge of $45.00 for all no-show appointments or appointments that are cancelled or rescheduled less than 48 hours. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $45.00 will be charged to you; the cancellation fee will be the responsibility of the patient; it cannot be billed to your dental/medical insurance and it must be paid in full before your next visit. Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and a $45.00 cancellation fee will be charged.

This policy will allow us to better utilize available appointments for all patients in need of dental care. When you do not keep your reserved time, you are affecting many people, including the following:

- The doctor's time
- The staff's time
- Your dental needs
- Another patient's time that could have utilized that time period

Our goal at Verma Dental is to provide exemplary dental care to patients in a timely manner. We understand that emergencies/illnesses occur unscheduled and we will take those incidents into consideration on a case-by-case basis, but please understand that the charge may still apply. We appreciate your cooperation in this matter.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have, 972-279-9494.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Verma Dental Appointment Cancellation Policy.

Patient/ Guardian Signature: _____ Date: _____

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, and CareCredit. Note, Additional fees will be applied for returned checks. All account balances over 90 days are subject to a $35.00 late fee.

Do you have insurance: As a courtesy to you, we will help you process all of your dental 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. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan. 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 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. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express and CareCredit at the time we provide the service to you. Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. 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 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.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Consent: 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. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Unpaid account balances: Any accounts with an outstanding past due balance of 90 days or older will be subject to collections. Statements will be sent to address provided, upon receipt patient or legal guardian for minors are responsible for balance not paid by insurance. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Payments plans will always be available to patient of record for balances not paid by dental plan. If a payment plan is arranged, you must comply with such agreement and complete payment plan or pay in full to avoid your account being subject to collections. We do not charge any interest on any account balances; it is your responsibility to communicate with us upon receiving any mailed statements with balances due.

Communications with you: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Patient/ Guardian Printed: _____

Patient/ Guardian Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's notice of Privacy Practices.

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)

_____

_____

_____