Patient Registration

Patient information (Confidential)

Name First ____________________ Middle____________________Last _______________________

Patient's Date of Birth___________________ Patient's Social security no:_______________________

Address____

City____________________ State____________ Zipcode_____________County:__________________

E-Mail:_________________________ Sex: Male/Female Marital status: Single/Married/divorced

Home Phone:___________________________ Office phone:__________________________________

Cell Phone 1:____________________________ Cell phone 2:_________________________________

Drivers License number____________________ State______________ Expiration date_____________

Emergency contact name:______________________ Phone No________________________________

Responsible party for the account:

Name of the person **Responsible for this account**_______________________________________

Relationship to patient_________________Contact tel. Number___________________________

E-mail address:_______________________ Social security no;_____________________________

Address:____

Email_____________________________________ Cell:______________________________________

Drivers license number:__________________State:___________Expiration date_____________

Is this person a current patient in our office: Yes/ No Please circle

Your Dental Insurance information (primary):

Name of insured_______________________________ Relationship to patient_______________

Date of birth________________Social security No:_________________

Effective start date of current coverage:__________________________

Effective date of employment__________________Name of employer____________________

Address of employer:__________________________ city_____________State____ Zip_______

Dental Insurance carrier_________________Policy No:_______________Group No:__________

Insurance carrier address____

Yearly dental deductible amount_____________Annual maximum_______________________

Amount used year to date________________Insurance carrier tel Number:________________

Claim address:____________________city_______________state_______ Zip_____________

You as the patient is responsible to get this information from your dental insurance carrier prior to your scheduled appointment. Due to privacy regulations we are not responsible.

If you have secondary Dental insurance please complete the following, If not write N/A

Name of insured_______________________________ Relationship to patient_______________

Date of birth________________Social security No:______________

Effective start date of current coverage:__________________________

Effective date of employment__________________Name of employer____________________

Address of employer:__________________________ city_____________State____ Zip_______

Dental Insurance carrier_________________Policy No:_______________Group No:__________

Insurance carrier address____

Yearly dental deductible amount_____________Annual maximum_______________________

Amount used year to date________________Insurance carrier tel Number:________________

Claim address:____________________city_______________state_______ Zip_____________

You as the patient is responsible to get this information from your dental insurance carrier prior to your scheduled appointment. Due to privacy regulations we are not responsible.

Today's chief complaint and dental History:

Last dental visit____________________What was done?______________________________

Previous doctors name_________________________ Address:______________________________

Tel No:____________________ Reason for today's visit_________________________________

Please circle the following:

Does you gums bleed? Yes/No ____

Do you have bad breath? Yes/No ____

Do you brush? Yes/No Frequency_________________________________

Do you Floss? Yes/No Frequency_________________________________

Do you use mouthwash? Yes/No Frequency_________________________________

Teeth sensitivity? Yes/No ____

Night grinder/Clencher? Yes/No ____

Frequent headaches? Yes/No ____

Mouth Lumps/ulcers ? Yes/ No ____

TMJ symptoms ? Yes/No ____

Prolonged bleeding? Yes/No ____

Like your smile? Yes/No ____

What do you like changed?____

Want white teeth ? Yes/ No ____

Other ____

Are you willing to commit to your Dental health by coming to our office every 6 months, so we can Professionally clean your teeth, Do a comprehensive oral examination and necessary X-rays to prevent dental problems on a preventive basis and treat existing ones. In our office we follow a strict protocol for preventive dentistry? Yes/ No ____

Our prevention protocol includes: 1.Coming to our office every six month for our Professional check up, cleaning and Xrays 2. Your in home care which includes brushing 2 times a day, flossing twice a week and 3. Partner with us to help us help you in maintaining excellent Oral and systemic health.

It is your health and only you are responsible for it.

Medical History: **Please circle the following**

Do you smoke? Yes/No Frequency____

Do you drink alcohol? Yes/No Frequency____

RXMedications taken yes/No ____

Non RX Medications:____

Controlled substances? Yes/No____

High BP?	Yes/ No	Leukemia?	Yes/No
Heart attack ?	Yes/No	Kidney disease	Yes/No
Rheumatic Fever?	Yes/No	AIDS/HIV	Yes/No
Swollen ankles?	Yes/No	Thyroid problem	Yes/No
Diabetes?	Yes/No	Hear murmur	Yes/No
Allergic to epinephrine	Yes/No	Angina	Yes/No
Allergic to Penicillin or drugs	Yes/No	Anaemia	Yes/No
Fainting/seizures?	Yes/No	Cancer	Yes/No
Asthma	Yes/No	Arthritis	Yes/No
Low BP	Yes/No	Hepatitis	Yes/No
Plates/screws in body?	Yes/No	Tuberculosis	Yes/No
Valvular defect in Heart	Yes/No	Liver disease	Yes/No

Other____

Consent for Dental treatment, Authorization and release:

- I certify to the best of my knowledge that what I have filled in this form is complete and accurate.
- I understand that providing incorrect information can be dangerous to my health.
- I authorize Dr.Selvan and his staff to release/share any information including the diagnosis and the records of any treatment or examination rendered to me or any or all members of my family during the period of treatment to third party insurance carriers/payors or other healthcare practitioners including dental and medical specialists. I authorize and request my insurance carrier to pay directly to Dr.Selvan's office any or all dental group benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services rendered by Dr.Selvan. I agree to be fully responsible for payment of all services rendered on my behalf or my dependents/family. I consent to the dental treatment discussed between me and Dr.Selvan. I will be given all the treatment options for all the necessary dental treatment customized to my needs. I will be encouraged to ask questions to my satisfaction and in detail. During my initial visit I give expressed consent to do the basic treatment such as Professional dental examination, X-rays and Professional cleaning or any emergency dental treatment or fillings of any kind. Individual consent forms for treatment will need to be obtained from me for individual or customized treatments if and when the need arises. Also I will keep Dr.Selvan's office updated with my most current dental insurance information, coverage, dental coverage eligibility information, addresses, contact info including e-mail for my insurance carrier etc without which the office cannot send my claims to my insurance carrier in a timely manner in which case I will hold myself fully responsible for all payments due Dr.Selvan's office. Also I understand that I am ultimately responsible for payment in full, due within 30 days irrespective of dental coverage with an insurance carrier or not. I do understand that in case of a collection action, I am fully responsible for the cost of the fees involved in addition to my balance due Dr.Selvan's office.
- I have read Dr.Selvan's office policy which I fully agree to and abide by it.

Signature of the Patient/ parent/Legal guardian: _________________________________

Print Name:____

Date: __________________________________

Dr.Selvan's Office Policy 2016

Welcome to our practice. To keep our office running efficiently, please adhere to the following:

- Call our office for an appointment 732-679-8300 or a request can be made on our website 24/7 www.DrSelvanDDS.com
- You can e-mail us anytime : drrvselvan@gmail.com
- The New Patient registration forms/Existing Patient forms are on our website. Print, complete then fax it or e-mail it to us well ahead of your scheduled appointment date. You can also complete the form in our office.
- Fax or e-mail us the front and back of your current dental insurance card.
- Please be in our office 15 minutes prior to your appointment time with your photo ID and your current dental insurance card.
- Please have all phones turned off and on vibrate or silence as a courtesy to everyone in the office including other patients.
- You are responsible to provide us with your **current**: address, phone numbers, e -mail, Dental insurance and medical history.
- When we schedule an appointment for you, the time is blocked and the Dental chair is prepared exclusively for you.
- Our appointments are planned and set one week ahead. All appointments are confirmed by us with you a week ahead of your scheduled appointment. There will be a charge of **$100** per person per appointment, for no shows and for last minute cancellations. This payment must be made prior to rescheduling. Failure to pay will result in the collection process at your expense. If you come in late after your appointed time, you will have to wait until all the scheduled patients are seen or get another appointment at a later date.

- Our time and yours is valuable so be considerate and be on-time for your appointment.

About us as a Provider:

- Dr.Selvan is a Dentist with 25 years of experience. He has served in many capacities in the field of dentistry including guest lecturer and as dental faculty. He is very kind, gentle, caring, passionate and easy to talk to. Please see our website for his noted accomplishments.
- We welcome your questions, will treat you with respect and dignity, understand your fears and answer your questions. We will provide you with treatment options customized to your dental situation. We are very passionate in what we do and will provide you with the best of care.
- We promise to have a safe and clean facility for you to come in and relax & share your experiences. You may bring in your headphones and music if that helps you relax. Evening and weekend appointments at our discretion.
- We will have refreshments and beverages for you as well. Warm Cotton hand towels will be provided for your comfort.
- Dentistry is a 50% partnership between the patient and the dentist. Each side needs to do their part for it to work. For example; the dentist does his part in the office and then the patient has to do his/her part at home including practicing good daily oral hygiene. It is of the upmost importance that you come in every six months for your regular dental prophylaxis. This will maintain your dental and overall oral health.
- We are children and senior friendly. Understanding your fears at any age.
- Our mouth is working 24/7. This includes night grinding, reduced salivary flow at night, increased bacterial activity, clenching both during day and night, chewing ice cubes etc. **Physicians are NOT trained in dentistry.** They treat every part of the body other than the mouth. We are the specialists of your oral health. Make use of our experience and expertise by maintaining a periodic check up regimen every six months for your benefit and overall health.

About Dental Insurances:

- A Dental insurance policy is a contract between your employer and the insurance carrier. Your employer is providing this dental policy as a benefit to you at a lower cost to them.
- You have a limited dollar maximum for dental (approx. $1000) per year.
- Please understand your insurance card is **not** a platinum card. It is only a benefit. You can use it or lose it. The unused portion cannot be carried over to the next calendar year.
- Since we are running a business in the 21st century with antique prices, please do not negotiate with us regarding payment of your share of cost determined by your carrier.
- On a Healthcare standpoint it is wise to come in for your dental check up every six months to avoid future problems and to sustain good health. It is in your best interest to keep up with your dental and oral hygiene. If you have dental insurance you should utilize your benefit to ensure your dental well-being.
- As a courtesy to you as our patient, we will file all dental claims/ pre-treatment estimates on your behalf at no cost to you the first time. Please understand that if we do not get paid within 30 days after we file your claim, you are responsible to pay us in full. All unpaid bills will be sent to collection at your expense.
- There will be a $5.00 charge to you for us to resend any claims and/or pre-treatment estimates/ to your insurance company if the situation arises.
- There will be a charge of $5.00 for each statement we send you and a 3% charge for all credit card transactions over $250.00
- There will be $50 charge plus bank charges for all bounced/bad checks.
- In case of pre-determinations, we will submit the paperwork on your behalf to your dental carrier along with supporting documents but it is up to you as the patient to follow up with your dental insurance carrier and provide us with the approval prior to scheduling for the procedure.

- All copayments due us must be paid in full at the time of treatment. There is no negotiation.
- THANK YOU FOR YOUR PATRONAGE.
- If you have any questions or concerns, please contact us at 732-679-8300 or e-mail - drrvselvan@gmail.com .
- At your request you will be given a copy of this policy.

  Please sign below.

  Patient/legal guardian: ________________________________

  Print Name:____

  Date:_______________________