For Office Use Only

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Paramjit Everest DDS

New Patient Information

Date:_____

Name:_____ Date of Birth:_____

Social Security#:_____ Home Phone #:_____ Cell #:_____

Mailing Address:_____

City_____ State_____ Zip:_____ Email Address:_____

Occupation:_____ Employed By:_____ How Long?_____

Spouse/Parent/Other:_____ Date of Birth:_____ Cell#_____

Address:_____ City:_____ State:_____ Zip:_____ Home#_____

Who may we thank for referring you to our office?_____

Primary Dental Insurance _____ Name of Insured:_____

Member ID #_____ insurer`s D.O.B :_____

Place of employment:_____ Date of Birth of Insured:_____

Secondary Dental Insurance? _Y / N__ Insurance Carrier:_____ Insurer DOB:_____

Name of Insured:_____ Member ID # Of Insured:_____

In Case of an emergency, who should be notified?_____

Relationship to patient_____ Contact Phone Number_____

Preferred Pharmacy:_____ Location_____

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. The benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are required *to* collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at the time of the service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this. I authorize the release of information necessary to process my dental benefit claims.

I hereby authorize payment directly to Paramjit Everest DDs. _____ (initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions regarding the Notice.

Signature _____

Please read the following before signing:

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any changes in my health, or if my medications change, I will inform the Doctor. I authorize the Doctor to perform any necessary dental treatment for my minor child or me. I understand that the details of the treatment will be provided for me, and I will be allowed to ask questions prior to actual treatment.

Possible risks and consequences include Drug reactions and side effects, post- operative bleeding and/or pain, post-operative infection and/or bone inflammation, jaw joint malfunction and/or pain, need for root canal therapy after any filling, crown, partial crown, veneer or gum therapy, and/or loss of teeth. If any of these consequences occur, I understand that I am financially responsible for any additional treatment.

Financial and Insurance Information:

I understand that Dr. Everest accepts most dental insurance. I understand that even if I have dental insurance, I am financially responsible for all fees for my treatment not covered by my dental insurance. I authorize Dr. Everest to release any information to my insurance company that is needed to process a claim. I understand that payment is due at time of service. If I receive a dental exam and x-rays free of charge and choose to request my x-rays, I will be responsible for the fee associated with the free services.

Consent for E electronic Communication and Voice Mail Consent

By Utilizing our practice's electronic services, you agree that Dr. Everest may send to you, correspondence using the email address you provided and or the phone number you have provided. hereby give consent for the Practice to call me by phone at the phone numbers provided and to leave voice messages and/ or to leave a message with the person answering the phone.

Limited Warranty:

If any crown, partial crown or veneer has a problem (unrelated to a patient's lack of home care, a traumatic injury or misuse of teeth) within 3 years after placement, we may repair it or replace it. This warranty does not apply to restorations placed on teeth with a root canal procedure. Depending on the circumstances, we may repair it or replace it at no charge, prorate the charge, and/or the patient may be responsible for any additional laboratory and/or material costs. If a patient has not kept on schedule with his/her recommended regular cleanings, annual fluoride treatments or periodontal maintenance appointment, this warranty does not apply. For this warranty to apply, all treatment planned for the same quadrant, as the warranted tooth must be completed within one year of placement of the crown/veneer.

Arbitration Agreement:

To control the increasing costs of dental care, any claims or disputes against this office shall be resolved by "binding arbitration." By signing this agreement, the patient agrees with the office of Dr. Paramjit Everest DDS that any dispute relating to
dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment or care of the patient, including the scope of the arbitration clause and the arbitrability of any dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement

(including associates), shall be resolved by binding arbitration by the American Arbitration Association, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge or jury, an agrees that all such claims will be resolved as described in this section.

Consent for Treatment:

I have read the above information and have had an opportunity to ask questions. I understand that if I have any future questions, concerns, constructive criticism or complaints, it is my responsibility to contact Paramjit Everest DDS at one of the numbers below, or in writing. You can reach the Doctor by the following means: e-mail: smilesavers@hotmail.com. Office: (530) 673-7171

We require all patients to give our office no less than 2 business days' notice for any cancellations, reschedules or changes in appointments. After 3 short notice reschedules or no shows by a patient, the patient will be dismissed from our practice.

There is a charge of $25.00 that will be charged to your account if you make an appointment, don't cancel or reschedule but simply no show.

_____ _____

Patient or Guardian Signature Date

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Type/ Date of surgery: _____		
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexually transmitted disease
Yes / No Pacemaker		
Date implanted: _____		
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening of arteries	Yes / No Emphysema or other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium or sedatives	Yes / No	Codeine or other opioids
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Antidepressants	Yes / No	Herbal supplements		

Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: _____

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, how many months? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you tested positive for COVID-19?
If YES, date of positive test result: _____

Yes / No Are you experiencing any ongoing or lasting symptoms or effects as a result?
If YES, what are these symptoms or effects? _____

Yes / No Are you currently under the care of a physician or taking any medications for any of the conditions listed above?
If YES, please list _____

If patient answers "yes" to any of the questions above, consider seeking additional information from the patient regarding their symptoms and medications, prior to treatment.

Yes / No **Are there any issues or conditions that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?):

Name: _____ **Relationship:** _____ **Phone Number:** _____

I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HIPAA Compliance Patient Consent Form

Our Notice Of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your dental conditions with any member of your family?	YES	NO

If YES, please name the family members allowed:

_____

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____