Dr. Satnam S. Bedi DMD, MS, PA
10481 Spring Hill Dr. Spring Hill, FL 34608
Phone: 352-683-1845 Fax:352-683-2111

First Name: _____ Last Name:_____
Address:_____City, State:_____
Zipcode:_____ Home Phone: _____
Cell Phone:_____Social Security #: _____
DOB: _____ Sex: _____ Single Married Widow Divorced
Email Address:_____
Employer :_____

Emergency Contact
Name_____ Relationship_____
Phone # _____ Email _____

How did you hear about us today?

- ☐ Google
- ☐ Yellow pages
- ☐ Facebook
- ☐ Radio
- ☐ Newspaper
- ☐ Friend Name_____
- ☐ Other _____

ANCHOR DENTAL CARE

Dental Insurance Information

☐ No Insurance

Be sure to ask about our In-Office Discount Dental Plan!
Makes getting dental work and cleaning more affordable for the whole family!

Dental Insurance Information

Insured's Name _____
Policy Holders Name _____
Policy Holders Social _____
Policy Holders Date of Birth _____
Policy Holders Relationship to Patient _____
Insurance Company _____
Policy ID# _____
Group # _____

☐ Check box to keep signature on file for insurance co.

(What this does is allow us to send it through to the insurance company electronically. This normally leads to a faster response time.)

Please be advised, we are NOT in-network with the dental insurance companies. We file claims as OUT OF NETWORK fee coverage. (Out of network is covered by most PPO plans)

The initial claim we will gladly submit, but any appeals will need to be handled by the patient. By signing above, you verify that you understand our office's insurance policies and coverage.

_____ _____

Policy Holder's Signature Date

ANCHOR DENTAL CARE

Health History Page 1

Please Answer the following:

Are you currently under physicians care? ___Y ___N

Have you ever had a heart attack? ___Y ___N

Do you use tobacco products?(smoke / chew) ____ Y ___ N

Do you use a controlled substance? ___ Y ___ N

Do you take **BLOOD THINNER**? ___Y ___ N

If YES to any of the above, please explain:

_____

_____

_____

LIST ALL MEDICATIONS YOU CURRENTLY TAKE (DOSES/REASONS):

_____

_____

Are you **ALLERGIC** to the following:

☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Local Anesthetics

PLEASE LIST ANY OTHER ALLERGIES:

_____

_____

WOMAN:

Are you pregnant / trying to get pregnant? __Y__N

Taking ORAL contraceptives? __Y __N

Nursing? __Y __N

_____ _____

Signature Date

ANCHOR DENTAL CARE

Health History Page 2

Do you have, or have you ever had any of the following? If YES please explain:

AIDS/HIV	___Y ___N	Hepatitis	___Y___N
Alzheimer's Disease	___Y ___N	High Blood Pressure	___Y___N
Anemia	___Y___N	Hypoglycemia	___Y___N
Artificial Heart Valve	___Y___N	Joint Replacement	___Y___N
Artificial Joint	___Y___N	Low Blood Pressure	___Y___N
Asthma	___Y___N	Mitral Valve Prolapse	___Y___N
Blood Disease	___Y___N	Pain in Jaw or Joints	___Y___N
Breathing Problems	___Y___N	Rheumatic/Scarlet Fever	___Y___N
Cancer	___Y___N	Shingles	___Y___N
Chemotherapy	___Y___N	Sinus Trouble	___Y___N
Diabetes	___Y___N	Stomach/Intestinal	___Y___N
Epilepsy or Seizures	___Y___N	Stroke	___Y___N
Excessive Bleeding	___Y___N	Thyroid Disease	___Y___N
Fainting/ Dizziness	___Y___N	Tuberculosis	___Y___N
Frequent Headaches	___Y___N	Tumors or Growths	___Y___N
Heart Problem (ANY)	___Y___N	Venereal Disease	___Y___N
Heart Pace Maker	___Y ___N		

Explain above Conditions checked "YES":

_____

_____

_____

Do/Have you had any other illness not listed_____

Medical Doctor:_____

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 health. It is my responsibility to inform the doctor and dental staff of any changes in my medical status, including prescriptions or over the counter medications or supplements I am taking.

_____ _____

Signature Date

ANCHOR DENTAL CARE

Dental History Form

Please Respond to the following, And "YES" answer please explain:

Do you feel your gums are shrinking away from your teeth?	__Y__N
Do your gums bleed when you brush or floss?	__Y__N
Do your jaws feel tired when you wake up in the morning?	__Y__N
Do your jaws feel tired at the end of the day?	__Y__N
Do you think your teeth are moving or shifting?	__Y__N
Have you ever had a very sore mouth?	__Y__N
Do your teeth feel sore when you bite?	__Y__N
Do any teeth feel high or long when you bite?	__Y__N
Where do you think your teeth hit first?	_____
Do you frequently press your tongue against your teeth?	__Y__N
Have you ever had a gum boil or abscess?	__Y__N
Does meat or food wedge between your teeth easily?	__Y__N
Have you noticed a change in the way your teeth fit together?	__Y__N
Do you grind or clench your teeth?	__Y__N
Do your jaws click, pop or hurt when yawning or opening wide?	__Y__N
Do your jaw muscles frequently get tired or sore?	__Y__N
Do you have difficulty opening wide?	__Y__N
Do you experience ringing in your ears?	__Y__N
Have you ever been in a car accident, major or minor?	__Y__N
Have you had any significant dental treatment in the past?	__Y__N
Have you ever had a sport injury and/or trauma to the head or neck?	__Y__N
Do you work at a desk, computer or in a forward head position?	__Y__N
Do you experience any sleep problems?	__Y__N
Do you get headaches that require medications?	__Y__N

_____

_____

_____

_____ _____

Signature Date

ANCHOR DENTAL CARE

By signing below, I acknowledge that I have read and understand the following general office policy information.

PAYMENT FOR SERVICES

Payment in full is due at the time services are rendered. Payment may be made in the form of cash, check, MasterCard, Visa, American Express and Discover. Credit applications for outside financial assistance are available upon request. All insurance balance are the patient's responsibility after 60 days.

Balances that are not paid will be placed over to a collection agency, there will be additional fees that the patient will be responsible for.

BROKEN APPOINTMENTS

In order to maintain efficiency in the office to better serve you, we respectfully request a 24-hour minimum notice change of appointment. If appointments are missed or cancelled without notice, a corresponding fee may appear on your account.

Thank you.

_____ _____

Signature of Patient **Date**

_____

Print Name

_____

Witness Signature

_____ _____

Print Witness Name **Date**

PHONE: 352-683-1845 FAX: 352-683-2111 www.AnchorDentalCare.com

ANCHOR DENTAL CARE

2015 HIPPA Privacy Authorization Form

Patient Name: _____ Date of Birth: _____

Please list the name and relationship of all persons that you authorize *Anchor Dental Care* to release your dental information to during the course of your car.

Name: _____ Relation: _____
Name: _____ Relation: _____
Name: _____ Relation: _____

I hereby authorize all medical sources to release and disclose the following protected health information to:

Anchor Dental Care
10481 Spring Hill Dr. Spring Hill, FL 34608
Fax: 352-683-2111

Specific information to be discussed:
Entire Medical Record
Only information related to:
_____
Only the periods from
_____ to _____
Other:

The information for which I'm authorizing disclosure will be used for the following purpose:

Further Dental Treatment
My Personal Use
Other:

I understand that the information described above may be re-disclosed by the person or group that I am giving the Agency permission to disclose and therefore my information may no longer be protected by Federal privacy regulations. I understand that I may inspect or request copies of any information disclosed by this authorization if the Agency initiated this request for disclosure.

I understand that I may revoke this authorization by notifying the Agency in writing with the understanding that previously disclosed information would not be subject to my revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for health care services or eligibility for benefits.

_____ _____
Signature of Patient/ Patient Representative Date

_____
Printed Name of Patient

_____ _____
Witness Date