

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

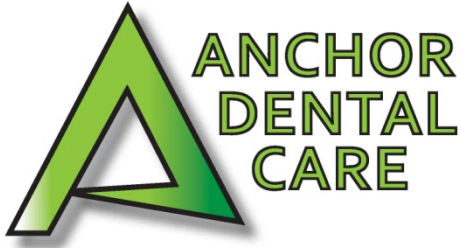
First Name: _____ Last Name: _____
Address: _____ City, State: _____
Zipcode: _____ Home Phone: _____
Cell Phone: _____ Social Security #: _____
DOB: _____ Sex: _____ Single Married Widow Divorced
Email Address: _____
Employer: _____

Emergency Contact

Name _____ Relationship _____
Phone # _____ Email _____

How did you hear about us today?

- Google
- Friend Name _____
- Yellow pages
- Other _____
- Facebook
- Radio
- Newspaper



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.

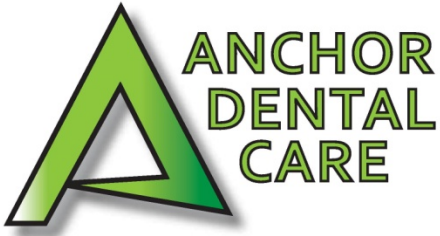
(What this does is allow us to send it through to the insurance company electronically. This normally leads to a faster response time.)

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



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:

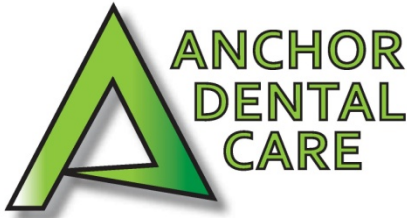
Are you pregnant / trying to get pregnant? ___Y___N

Taking ORAL contraceptives? ___Y___N

Nursing? ___Y___N

Signature

Date



Health History Page 2

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

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

Explain above Conditions checked "YES":

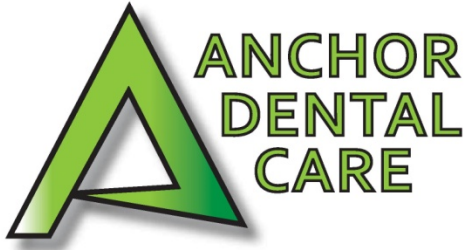
Do/Have you had any other illness not listed _____

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



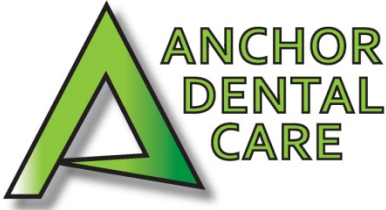
Dental History Form

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



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.

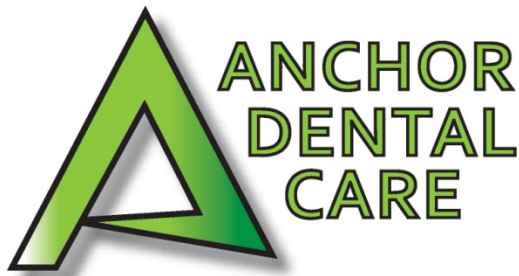
Thank you.

_____ _____
Signature of Patient **Date**

Print Name

Witness Signature

_____ _____
Print Witness Name **Date**



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