MVP DENTISTRY
GENERAL & COSMETIC DENTISTRY
Mitul V. Patel, D.D.S.

THE OFFICE OF
MITUL V. PATEL, D.D.S. P.C.

774 POST ROAD, SUITE 250
SCARSDALE, NEW YORK 10583
OFFICE (914) 427-3400 FAX (914) 726-3406
Website: mvpdentistry.com

Patient Information

Patient Name: _____ Date: _____
First MI Last Preferred Name

Email: _____ Gender: ____ Marital Status:_____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext_____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient (self) ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Health Information

Date of last dental visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergic:
Medications/Latex/Food
_____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes Type 1 or 2
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injury
☐ Heart Disease
Heart Attack _____
☐ Heart Murmur
☐ Hepatitis-Type _____
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due Date:_____
☐ Radiation / Chemo
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke _____
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ I have used Fen-Fen

Premedication Required
Yes / No

☐ Heart_____

☐ Joint_____

☐ Other Conditions
_____
_____

- Are you taking any medications? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician other than regular check-ups? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any serious problems associated with previous dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____

Responsible Party Information

The person responsible for payment is: ☐ the patient (self) – same address as on the first page ☐ other – please fill out below

Name: _____

Relationship to the patient: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street City State Zip Code

Insurance Information

PRIMARY POLICY

Insurance Company Name: _____

Name of Policy Holder: _____
First MI Last

Policy Holder's Birth Date: _____ SS#/ID# _____ Group# _____

Policy Holder's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SECONDARY POLICY

Insurance Company Name: _____

Name of Policy Holder: _____
First MI Last

Policy Holder's Birth Date: _____ SS#/ID# _____ Group # _____

Policy Holder's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Referral Information

Whom may we thank for referring you to our practice? _____

Consent for Services

CANCELLATION FEE -To avoid a cancellation fee, our office requires a 24 hour notification to postpone, reschedule or cancel a scheduled dental appointment. Any failed appointments will be charged a cancellation fee based on the appointment time scheduled. Any messages left on our answering machine will have a date/time stamp per message.

PATIENT PRIVACY-Due to patient privacy and safety, only the patient is allowed to be in the operatory.

INSURANCE & ADDRESS CHANGES-Please notify the office if your insurance policy has changed or terminated prior to your appointment.

NEW PATIENTS-New patients scheduling for their first appointment will typically have an exam, x-rays and a cleaning. We do not provide a treatment plan for the first visit. As the patient or parent of a minor patient, please make financial arrangements prior to your appointment if necessary. Otherwise, we will proceed with the scheduled appointment.

CONSENTS & PAYMENT-As a condition of your treatment by MVP Dentistry, financial arrangements and treatment consents must be made prior to receiving any dental treatment.

FINANCE CHARGE/RETURN CHECK FEE-A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. Returned bank checks will be charged $35 per transaction.

As a courtesy to our patients who carry dental insurance, MVP Dentistry will file and submit all insurance claims on your behalf. You are responsible to pay your estimated portion at the time of service. Estimated insurance benefits are subject to actual payment by your insurance carrier. Ultimately, you will be responsible for any remaining balances.

I understand that the estimated fees listed for my dental treatment can only be extended for a period of 90 days and insurance rates can change at any time without notice.

In consideration for the professional services rendered to me by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Dr. Patel & employees to call my home, work, cell and/or email to discuss matters related to this form and/or other dental treatment.

I acknowledge that upon my request, I may receive a copy of the Dental Materials Fact Sheet (adopted by the Dental Board of California, dated October, 2001).
I acknowledge that, upon my request, I can be furnished with a copy of this office's Notice of Privacy Practices.

I have read the above conditions for my dental treatment and consent of services and agree to the MVP Dentistry office policies. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, insurance and contact information, I will immediately inform the MVP Dentistry office.

_____ Date: _____

Signature of patient or parent/guardian

_____ Date: _____

Signature of treating dentist