KDental Frisco PC.

3010 Legacy Dr Ste 130, Frisco, TX 75034, Phone: (972)964-7777
WWW:Kdentalfrisco.com

Welcome to KDental Frisco. It is our pleasure to serve you as you have chosen our practice to care for your oral health. In our office, you will experience the subtle differences and team dentistry at its finest. We are delighted to share the most hi-tech quality of equipments and materials that will provide you the best dental care experience. Dr. Monika and valued team members strive to provide you superior dental care, in a warm and caring environment.

During your appointment, we will gather a variety of detail medical and oral diagnostic data. This includes an oral cancer screening, evaluation of your periodontal health, necessary radiographs, and intra-oral images that reveal detailed information about not only your teeth but your oral tissues with deep pockets. All of this data is evaluated to derive the most comprehensive treatment plan for you to maintain optimal preventive oral health.

We now know there is compelling evidence to suggest a link with your oral/periodontal health and many systemic health diseases such as, cardiovascular disease, diabetes, chronic inflammatory diseases and dementia. This emerging evidence makes it vital that you provide our office with a detailed medical history.

We focus on specific goals you have for your mouth, teeth, smile and overall health in order to customize a treatment plan just for you. Be thinking about what goals you have, therefore, when we ask your expectations, you can share them with us.

• New patient comprehensive dental experience, 2 hours

• Please allow 48 hours notice for schedule changes

• We encourage you to return the new patient packet 1 week prior to your scheduled appointment, so our team can be fully prepared for you.

We look forward to exploring and achieving your goals in most comfortable way. For more information about our practice, please visit our website at www.kdentalfrisco.com.

Sincerely,

Dr. Monika Kumar, DDS

Welcome to KDental Frisco PC.

PATIENT INFORMATON

Patient Name: _____ Birth Date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____

Cell: _____

Work: _____ Gender: M or F

Emergency Contact: Name: _____

Relationship: _____

Phone: _____

How did you hear about us? _____

INSURANCE INFORMATION

Name of Insured: _____

Subscriber ID #: _____

Insured: _____

Employer Name: _____

Insurance Company _____

Insurance Claims Mailing Address: _____

Insured's Birth Date: _____

SS#: _____

Group Number: _____

Is insured a patient? Yes or No
Phone: _____

Please describe the main reason for your consultation/new patient appointment with Dr. Kumar. (How long has this issue been going on & what other past events apply?)

_____

_____

Please rate your smile. Dislike 1 2 3 4 5 6 7 8 9 10 Satisfied

When was your last dental examination? _____

Current home care: _____

Brush: Manual or Electric

How often? _____

Cleaning? _____

X-rays? _____

Floss: Daily Occasionally Rarely Occasionally Every day

Circle previous dental procedures experienced:

Whitening Take-home trays / Zoom in-office Night guard / retainers Cosmetic veneers/ crowns Implants Ortho/Invisalign

PLEASE RATE THE IMPORTANCE OF THE FOLLOWING GOALS

Optimal Preventative Care: Not important 1 2 3 4 5 Very important

(proactive approach to underlying problems, preventing issues before they arise)

Optimal Restorative Care: Not important 1 2 3 4 5 Very important

(removing old metal fillings, cavity prevention products, protecting dental work)

Cosmetic Options: Not important 1 2 3 4 5 Very important

(Invisalign, whitening, porcelain veneers, anti-aging)

Dental Wellness Approach: Not important 1 2 3 4 5 Very important

(sleep apnea/snore device, Oral DNA testing/heart disease, nutritional recommendations)

Please share your individual dental goals. -

_____

_____

_____

Please share any concerns about treatment, timing, finances or anxiety.

_____

_____

DO YOU HAVE ANY OF THE FOLLOWING?

- Discolored or dark teeth? Yes or No
- Old unsightly crowns with black lines? Yes or No
- Spaces between your teeth? Yes or No
- Crowded or crooked teeth? Yes or No
- History of orthodontic treatment? Yes or No
- Any history of gum disease? Yes or No
- Red, swollen, bleeding or receding gums? Yes or No
- Chipped, thin, or worn down teeth? Yes or No
- Clenching or grinding your teeth? Yes or No
- TMJ, jaw, or muscle soreness? Yes or No
- Frequent headaches or migraines? Yes or No
- Do you have a night guard/NTI? Yes or No
- Cover your mouth when you smile? Yes or No
- Anxiety with dental work? Yes or No

FAMILY or SELF HISTORY:

Cardiovascular Disease: Father / mother / G Mother/ G Father/ Brother/ Sister

Stroke: Father / mother / G Mother/ G Father/ Brother/ Sister

Cancer: Father / mother / G Mother/ G Father/ Brother/ Sister

Diabetes: Father / mother / G Mother/ G Father/ Brother/ Sister

Bleeding Disorder: Father / mother / G Mother/ G Father/ Brother/ Sister

CURRENTLY UNDER CARE FOR THE FOLLOWING DENTAL/MEDICAL DOCTOR:

Dr. _____ Dr. _____

Dr. _____ Dr. _____

Dr. _____ Dr. _____

Dr. _____ Dr. _____

HOW MUCH /DAY:

Smoke: _____ How Many Years_____

Tobacco:_____How Many Years_____

Alcohol: _____How Many Years_____

Rec Drug_____**How Many Years**_____

LIST MEDICATIONS (Rx & Over-the-counter, Dosage, Frequency):

CURRENT ANTIBIOTICS:

CURRENT SUPPLEMENTS/VITAMINS:

ALLERGIES:

Dental Treatment & Information Acceptance Form KDental Frisco PC

Please initial each section

HEALTH INFORMATION:

I agree to disclose ALL previous illnesses, medications; medical, dental, and family history. Any undisclosed information or omissions could have a negative effect on my dental and oral health. I have been informed there are oral-systemic links that can affect my overall wellness.

_____

DRUGS, LATEX AND MEDICATIONS:

I understand that antibiotics and other medications can cause allergic reactions and/or anaphylaxis, which is potentially a life-threatening condition that can interfere with normal breathing. Latex allergies can cause rashes and itching. Epinephrine, which is used in some dental injections, increases heartbeat, and depending on my health status may be dangerous. Please, disclose any information on our health history forms pertaining to any known drug or latex allergies.

_____

DENTAL TREATMENT:

I authorize KDental Frisco to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate to my oral health needs. I also authorize Dr. Jill Wade, Dr. Kristi Moody to prescribe any forms of medication, and perform any therapy that may be indicated and agreed upon. It is possible that a tooth may require endodontic treatment (root canal), even after a filling or a crown is done depending on the depth of existing restoration or decay present. This is not always predictable from radiographs alone. I also understand that if my teeth are sensitive after treatment, I must contact the office for an appointment to adjust my bite.

_____

PORCELAIN CROWNS / VENEERS / BONDING & COSMETIC FILLINGS:

Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed without a remake. I have been counseled, informed and educated on how important it is to maintain a healthy balanced dental regimen achieved by complying with hygiene and dental treatment plans set out by Dr. Kumar. I understand that many factors contribute to my oral health: stress, clenching, grinding, acidity, diet and genetics. I am aware that most people grind their teeth subconsciously, which is damaging to the teeth and can break teeth or dental restorations. I have been informed about the need to wear an occlusal guard for protection, and a bite check is suggested.

Name Date

PHOTOGRAPHY RELEASE:

I understand that photographs, x-rays, and videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising, and professional publications.

HYGIENE THERAPY:

I understand that upon diagnosis of periodontal disease, I no longer fall under the category of a "routine" dental cleaning. The treatment is then categorized under the periodontal dental procedure codes which require additional services than "routine" cleanings. Bleeding gums and family history will contribute to this diagnosis.

HYGIENE APPOINTMENTS:

If I am more than 15 minutes late for my professional dental cleaning, I will either accept what treatment can be rendered in the remaining time, meaning a compromised dental appointment, or will reschedule and pay the $150.00 broken appointment fee.

LIMITATION OF INSURANCE COVERAGE:

KDENTAL FRISCO IS IN NETWORK PROVIDER FOR MOST of PPO DENTAL INSURANCE COMPANY. This means I am responsible for the Co-Pay/Deductable/denied payment due to exclusion clause or limitations or caps on payments by my dental insurance company. Most of the time KDental Staff has approximate estimate of insurance reimbursement till the final claim has been filed. If insurance does pays for my services and the cost of my treatment, I am responsible for the payment of dental services. KDental Frisco will file my dental insurance claims. Most insurance companies will allow assignment of benefits payable directly to the office, meaning that I only pay the ESTIMATED portion at the time of service. However, the portions collected are only an ESTIMATE, once my insurance claims clear there may still be a balance due. I agree to be financially responsible for what insurance does not cover.

48 HOUR NOTICE OF CANCELLATION:

I agree to give 48 hour notice for schedule changes or I will be subject to pay the broken appointment fee of $150.00.1 understand that leaving a message after hours before my appointment is NOT sufficient notice. We do realize there can be extenuating circumstances.

APPOINTMENT TIMES & EMERGENCY CARE:I grant permission for contacting me via telephone (work, home, or cell), email, or text to discuss matters related to my treatment, accounting, or dental appointments. It is our philosophy to be available to any patient in discomfort, or in an emergency situation. This courtesy is extended to all patients and we ask for your cooperation to only use the emergency contact line for true emergencies, such as, a broken tooth or severe dental infection causing swelling and pain.

FINANCIAL POLICIES & HIPAA:I have received and understand the financial policies of KDental Frisco. I am aware they follow protocol of HIPAA'S notice of privacy laws.

_____ _____

Name: Date Witnessed Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 9, 2002, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your health information to a physician or other healthcare provider providing you treatment. Payment: We may use and disclose your health information to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reasons except those described in this Notice. To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so. Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency situations, we will disclose health information based on a determination using our

professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. Required by Law: We may use or disclose your health information when we are required to do so by law. Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances. Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.) Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment or healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in an emergency). Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the Department of Health and Human Services.

KDENTAL FRISCO | DR. MONIKA KUMAR

SIGNATURE ON FILE | FINANCIAL OPTIONS | DENTAL INSURANCE

Please select your payment option

Option 1

I prefer to Pay In part or full and acknowledge that my claim will be filed on my behalf. After insurance benefits will be received by Kdental Frisco PC, Any applied and eligible payment will be charged to my credit card on file. The reimbursement process typically takes 4-6 weeks. Knowledge of insurance limitations and frequencies are the responsibility of the insured. Any extra or excessive payment received by the insurance or patients will be refunded as check after reimbursement from insurance company for the procedure.

* 5% courtesy with payment in full by cash.* Payment in full with Visa, MasterCard, and American Express with 5% will be charged as credit card processing fee. * All Delta Dental, United Concordia, or Blue Cross Blue Shield patients will select Option 1 as these policies automatically reimburse the Kdental Frisco PC.

Please file my dental insurance on my behalf and I will pay my estimated out-of-pocket portion at the time of service. Any remaining balance or credit may be applied to the following card. This option now Requires a credit-card on file. This reduces our overhead in billing and allows us to continue to accept assignment of benefits from your insurance.

Patient Name: _____

Use this card for entire Family? _____

Cardholder Name: _____

Card Type: VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Card Number: _____

Expiration Date: _____ CVV Code: _____

Signature: _____

Date: _____

We are committed to providing you the best possible care available. Our office is an out-of-network provider for ALL insurance plans due to the limitations they attach to treatment, regardless of the diagnosis.

If outside financing is used, (CARE CREDIT) the entire fee will be applied and your insurance reimbursement will be mailed directly to you.