HORIZON FAMILY DENTAL CARE
APPOINTMENT & FINANCIAL POLICIES

APPOINTMENT POLICY

We schedule time especially for you, therefore our office requires either 48/72 hours' notice to cancel or reschedule appointments. A fee of $75.00 for all doctors/hygienist will be charged for all missed/cancelled or rescheduled appointments where at least 48 hours' notice was not given. A fee of $100.00 for all Specialists will be charged for all missed/cancelled or rescheduled appointments where at least 72 hours' notice was not given. (Specialist consists of Endodontic, Periodontics, Oral Surgeon and Prosthodontics).

FINANCIAL POLICY

When scheduling any appointment, prepayment is required at the time the procedure is scheduled.
Special financial arrangements can be made prior to start of treatment, please feel free to discuss payment option when scheduling appointments.
We accept the following forms of payment: Cash, Personal Checks, Visa, Master Card, American Express, Discover, Flexible spending account (Visa/Mastercard), Care Credit financial.
Patients will be responsible for all returned checks fees ($45.00). If sent to collections, you understand that it is your financial responsibility to pay all court costs and all collections fees and /or attorney fees.

INSURED PATIENTS

We are happy that you have Insurance coverage to help offset the cost of your dental treatment. Please understand that dental insurance does not always cover 100% of your treatment, and you may have a deductible and /or co-payment that will be due. Please bring your dental insurance card. As a courtesy to you, we will file the necessary claim and if there is any discrepancy on payment that is received from the insurance carrier we will bill or credit any difference to your account. We must emphasize that as dental care providers, our relationship is with the patient and not the insurance company.

HIPAA (Health Insurance Portability and Accountability Act)

I understand that at any time I can view a copy of or request a written copy of the office HIPAA policy.

______________________________ ______________________

Patient/Account Holder Signature Date

HORIZON FAMILY DENTAL CARE

KULJEET BHANGRA, DMD **VIKASH PATEL, DDS** **PHILIP QI, DDS**

PATIENT REGISTRATION & MEDICAL HISTORY

(PLEASE PRINT CLEARLY)

Date: _____________ E-mail:__________________________________

Patient____

Last Name First Name Middle Name

Street Address:__________________________________ City:___________________ State:________ Zip______

Home # _____________________________ Mobile #_______________________ Work #_________________

Sex: ____ M ___F Age:___ Birthday: __________ Married ___ Widowed ___ Single ___ Minor______

Employed/School:_______________________________________ Occupation:____________________________

Employer/School Address:____ Phone:__________________

Spouse/Parent Name:_______________________________________ Spouse/Parent Birthdate:_______________

Spouse/Parent Employed by____________________________________ Occupation______________________

Who is responsible for this account? ___________________________Relationship to Patient_________________

Social Security# ___________________________Spouse/Parent Social Security#__________________________

Name of Dental Ins. Company:_______________________________________ Group#____________________

In Case of Emergency, who should be notified? _______________________________ Phone: ________________

How did you hear about us? ____

MEDICAL HISTORY

Physician's Name____________________________________ Date of Last Physical___________

Have you ever had any of the following? (Check boxes that apply):

__ Allergies __Asthma ___ Arthritis ___Artificial heart valves ___Circulatory Problems ___Cancer ____ Diabetes
___Epilepsy ___ Hernia Repair ___Hemophilia ___ Heart Murmur ___Headaches ___High Blood pressure ___HIV/AIDS
___Hepatitis, Jaundice or Liver Disease ___Joint, screws etc. ___ Low Blood Pressure ___Mitral Valve Prolapse
___Osteoperosis ___Pacemaker ___Pre-Med ___Psychiatric Care ___Respiratory Disease ___Rheumatic Fever
___Radiation Treatment ___Sinus Problems ___Stroke ___Thyroid Problems ___Tumors ___Ulcer ___Venereal Disease
Other:____

Please list ALL medications you are currently taken:

____

____

Please list any drug allergies that you are aware of or if you have had any adverse reactions to any medications:

____

____

Have you ever responded adverse to medical or dental treatment? ______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phell? These include combination of lonimin, Adlpex, Fastin (brand names phentermine) (fenfluramine) and Redux (dexfenfluailine) ___Yes or __ No

Are you under the care of a physician? ___ Yes or ___ No For what conditions?____

(Woman) Do you suspect that are pregnant? Y or N Due Date:______________ Are you nursing? Y or N

Patient/Guardianship/Patient Signature:____ Date_____________