Pleasant Smile Dental Care *Nurturing Family*

Dental Wellness

Dr. Nanda Manogaran *P: 360-652-0800 F: 360-652-0844*

16410 Twin Lakes Avenue, Suite J-107 Marysville, WA 98271

Patient Name _____ Preferred Name _____

Date of Birth _____ Occupation _____

Sex(circle) M F

Employer(if any) _____ Social Security Number_____

Patient Home Address_____

City _____ State ____ Zip _____ Home Phone _____

Cell Phone_____Work Phone _____Email _____

Spouse/Closest Relative _____Relationship _____ Phone_____

How did you hear about us? _____

Dental History: (please answer to the best of your ability)

Date of: last dental checkup _____ last dental cleaning _____

Name of Last Dental Office _____

Adverse reactions to anesthetics?_____

Date of most recent dental x-rays _____ Full Mouth or 1,2,3 teeth x-rays?_____

Office Policies:

1. 48 HOUR NOTICE REQUIRED FOR CANCELLATIONS.

2. $50.00 NO SHOW FEE per hour will be assessed to your account, if 48 hours notice is not given if you cannot keep your appointment.

3. Adult patients - ARRANGE FOR CHILDCARE. This provides a tranquil atmosphere for everyone.

4. BRING IN ONLY CHILDREN WITH APPOINTMENTS. Parents, please remain in reception area. Children are more cooperative when you are not watching. If you are uncomfortable with this request, inform the front desk.

5. All co-pays/deductibles for a service to be performed is due in full at the time of service.

Responsible Party/Patient name _____ *Relationship* _____

Signature _____ *Date* _____

Time 2:50 PM | Pleasant Smile Dental Care | Date 7/26/2023

Medical History 2022

Patient Name: | Birth Date: | Date Created:

Health problems/medications have an important interrelationship with dental care. Please answer as acccurately as possible. Thank you.

Please list PCP name, clinic, and best contact information.	◯ Yes ◯ No	If yes
Any operation(s), hospitalization(s), or head/neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do/Have you taken diet, or bone/osteoporosis medication?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Do/did use Tobacco? List: daily use, and mo/yr of start/quit.	◯ Yes ◯ No	If yes
Do you smoke Marijuana? List daily use, and mo/yr of start, and if use is recreational or medical.	◯ Yes ◯ No	If yes

WOMEN: are you:

Pregnant/Trying to get pregnant ◯ Yes ◯ No	Nursing ◯ Yes ◯ No	Taking Oral Contraceptive ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin	☐ Codeine	☐ Vicodin	☐ Metal
☐ Latex	☐ Sulfa Drugs	☐ Ibuprofen	☐ Local Anesthetics
☐ Penicillin/Amoxicillin	☐ Percocet		

Do you use controlled substances? ◯ Yes ◯ No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia/Extra Bleeding ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No	Hepatitis, Veneral Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	Anaphylaxis/Hives or Rash ◯ Yes ◯ No
Drug Addiction ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No	Anemia ◯ Yes ◯ No	Easily Winded/Emphysema ◯ Yes ◯ No
Herpes/Genital Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No	Angina/Chest Pain ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No
Rheumatism ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No
Scarlet Fever ◯ Yes ◯ No	Shingles ◯ Yes ◯ No	Artificial Joint/Heart Valve ◯ Yes ◯ No	Excessive Thirst/Dry Mouth ◯ Yes ◯ No
Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No	Asthma/Breathing Issues ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No
Heart Murmur/Arrhythmia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No
Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No
Stomach/Intestinal Disease ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No	Cancer/Tumors/Growths ◯ Yes ◯ No
Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid/Parathyroid issues ◯ Yes ◯ No	Chemo/Radiation Therapy ◯ Yes ◯ No
Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No
Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No	Sleep Apnea/Snoring ◯ Yes ◯ No	Grinding teeth ◯ Yes ◯ No

Do/did you have any serious illness that is not listed above?

I answered the above questions to the best of my knowledge. I understand it is my responsibility to provide accurate, current information, and that incorrect/invalid information may be dangerous.

Signature of Patient, Parent or Guardian:

X Date:_____

Pleasant Smile Dental Care *Nurturing Family*
Dental Wellness
Dr. Nanda Manogaran *P: 360-652-0800 F: 360-652-0844*
16410 Twin Lakes Avenue, Suite J-107 Marysville, WA 98271

Informed Consent for General Dentistry

1. Examinations and X-rays

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

Initial _____

2. Drugs, Medication, and Sedation

I have been informed and understand that antibodies, analgesics and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. Some anesthetic, drugs, or medications may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the medications that may have been prescribed to me for my dental care. I understand that failure to take medications prescribed for me in the manner indicated by the Dentist may offer risks-- which may include continued/aggravated infection, or pain. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

Initial _____

3. Changes in Treatment Plan

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make any/all changes and additions as necessary and compose a new proposed Treatment Plan. I understand that I must give signed consent to any treatment plans the Dentist presents as this demonstrates that each new treatment plan has been presented and explained to me.

Initial _____

4. Temporomandibular Joint Dysfunction (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

Initial _____

5. Dental Insurance Benefits

I understand that my insurance may provide only the minimum standard of care and that all remaining balance is my responsibility.

Initial _____

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating dentist, is responsible for my dental treatment. I understand that the Dentist and his staff will give me the maximum dental improvement that they can give me at every visit.

Patient/Responsible Party Signature :_____ **Date:** _____

Dr. Nanda Manogaran's Signature : _____ **Date:** _____

Pleasant Smile Dental Care

Nurturing Family

Dental Wellness

Dr. Nanda Manogaran

P: 360-652-0800 F: 360-652-0844

16410 Twin Lakes Avenue, Suite J-107 Marysville, WA 98271

Appointment Confirmation Policy

We have scheduled a dental appointment for you. We will be sending an automated reminder 3 weeks in advance; however, please be aware that you **must** contact us 48 hours before your appointment to confirm. If we are unable to communicate with you about your appointment, we will need to reschedule your appointment to a different day. To that extent, if we cannot get in touch with you, it is your responsibility to contact us to reschedule. Also, if, due to extenuating circumstances (ex: disconnected phone, etc), we are unable to contact you, it is your responsibility to contact us whether to confirm or reschedule your appointment.

_____

Patient Name

_____

Patient/Parent/Responsible Party Signature Date

Pleasant Smile Dental Care *Nurturing Family Dental Wellness*
Dr. Nanda Manogaran *P: 360-652-0800 F: 360-652-0844*
16410 Twin Lakes Avenue, Suite J-107 Marysville, WA 98271

FINANCIAL POLICY

Private Pay Patients:

Payment is required at the time of service unless prior financial arrangements have been made with this office. Accounts are not paid in full as of the following billing cycle (30 days) will be subject to monthly interest charges of 1.5% (18% APR) of the outstanding balance.

Insured Patients:

All insured patients will pay their estimated portion at the time of the appointment. We estimate and bill insurance as a courtesy to you. Every effort is made to create accurate **treatment estimates**; however, we are **not a party to your contract** to your insurance company. **Some, or all, of your treatment** may not be covered due to plan limitations that have not been disclosed to us.

Final determination of insurance payments will be made when your insurance receives the claim. Please remember, any decisions or agreements with your carrier are between you(the patient), and the insurance company and is beyond our control. **Any remaining balance will become your responsibility, including if any of the following occurs:**

- The treatment goes over your yearly maximum/denied by your insurance company.
- You are not eligible for insurance coverage/Insurance payment was less than previously estimated.
- You prevent or delay payment by not complying with requests relating to your insurance.
- You do not complete your treatment and it results in non-payment by the insurance company.
- Lab costs that incurred due to a missed appointment.
- You received an insurance check, and do not sent it to this office.

PRIVATE PAY/INSURED PATIENTS:
PLEASE NOTE: If you decide not to receive any treatment that includes lab work that has already been started/completed, the lab cost cannot be refunded.

Extended Payments:

Arrangements can be made to pay for the costs as presented to you in your treatment plan prior to getting the treatment done. Post-dated checks (restrictions apply) and credit cards are also accepted. We also offer an excellent credit program.

Please Note: Any accounts past 30 days without prior payment arrangements (or noncompliance with an existing payment arrangement) will be turned over to collection.

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see your records at any time. You may also ask to correct that record. If you request a copy of your records there will be a fee of $30. We will not disclose your record to others unless you direct us to do so in a **signed written request**, or if the law authorizes/compels us

to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY & ACKNOWLEDGEMENT AND AGREE TO ITS TERMS.

_____

Patient or legally authorized individual signature Date

_____

Printed name if signed on behalf of patient Relationship