Manik R. Khisti, DMD, PLLC

10322 Ironbridge Road, Chester, VA 23831

Phone (804) 717-5400 Fax (804) 717-5507

Patient Name _____ Preferred Name _____

DOB _____ Age _____ Gender _____ Marital Status _____

Address _____

City _____ State _____ Zip Code _____ SSN _____

Home # _____ Work # _____ Cell # _____

Email Address _____

Spouse's Name _____ Do you have children? Y / N How many? _____

If minor, parents' or guardians' names _____

Parent/ Guardian Employer _____ How did you hear about us? _____

Emergency Contact: Name _____ Relationship _____

Home # _____ Work # _____ Cell # _____

Dental Insurance Information:

Insurance Company _____ Group # _____ ID #_____

Subscriber's Name _____ Subscriber's Employer _____

Subscriber's DOB _____ Subscriber's SSN _____ Relationship to patient _____

Is the patient covered by additional insurance? Y / N If yes, please provide necessary information to staff.

Medical Information:

Physician's Name _____ Phone # _____ Date of last physical exam_____

Are you under the care of a physician (other than for routine physicals)? Y / N Are you in good health? Y / N

Have there been any changes in your general health within the past year? Y / N

If yes, what condition is being treated? _____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? Y / N

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medications? Y / N

Please list any prescription medications, over the counter medicine, vitamins, natural or herbal supplements, diet supplements and/or recreational drugs **on the attached form.**

Medical History

Endocrine:

- Type I Diabetes
- Type II Diabetes
  - Insulin Dependent
- Low Thyroid
- Overactive Thyroid
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Kidney Disease
- Dialysis

Respiratory:

- COPD
- Chronic Sinusitis
- Asthma
- Tuberculosis
- Sleep Apnea
- Seasonal Allergies

Musculoskeletal:

- Arthritis
- Artificial Joints
  Date(s):
  _____
- Osteoporosis
- Taking Bisphosphonates

Women, are you currently:

- Pregnant
  Due Date:
  _____
- Nursing
- Taking oral contraceptives

Mental:

- Alzheimer's
- Dementia
- Anxiety
- Panic Attacks
- Depression
- PTSD
- Bipolar disorder
- Autism spectrum
- ADHD/ADD

Gastrointestinal:

- Acid Reflux
- GERD
- Crohn's Disease
- Stomach Ulcers

Allergies / Adverse Reactions:

- Latex
- Epinephrine
- Penicillin or Amoxicillin
- Sulfa Drugs
- Erythromycin or Clindamycin
- Aspirin
- Codeine
- Pain medications
- Food :
  _____
- Dyes:
  _____
- Other:
  _____

Surgical History (type and year):

_____

_____

Neurological:

- Epilepsy
- Head Trauma
- Tremors
- Parkinson's
- Stroke
- Migraines
- Multiple Sclerosis

Cardiovascular:

- High Blood Pressure
- High Cholesterol
- Mitral Valve Prolapse
- Heart Murmur
- Heart Attack
- Cardiac Stent
  Date:
  _____
- Angina
- Pacemaker
- Artificial Heart Valve
- Anemia
- Sickle Cell Disease

Other:

- Cancer
  Type & Year:
  _____
- Chemotherapy
- Radiation therapy
- HIV+ / AIDS
- Hearing Impaired
- Legally Blind
- Lupus
- Sjogren's
- Autoimmune Disorder
- Other:
  _____

Have you returned from a foreign country in the last 30 days? Y / N If yes, are you feeling flu-like symptoms? Y / N

Do you have any disease, condition, or problem not listed that you think we should know about? If yes, list below:

_____

Do you use tobacco (smoking or smokeless)? Y / N

To the best of my knowledge, all of the information provided by me is true and accurate. If I ever have any change in my health, I will inform the doctor(s) or staff at the next appointment.

_____ _____ _____

Patient Name Patient, Parent, or Guardian Signature Date

Medication List

Patient Name _____ Today's Date _____

Please list any prescription medications, over the counter medicine, vitamins, natural or herbal supplements, diet supplements, sexual enhancement drugs, and/or recreational drugs you are currently using.

DRUG	DOSAGE	FREQUENCY	REASON TAKING

Dental History

Reason for today's visit _____

Name of previous dentist _____ Phone # _____

Date of last dental visit _____ Date of last cleaning _____

Have you ever had any complications following dental treatment? Y / N

If yes, please explain: _____

Are you satisfied with the appearance of your teeth? Y / N

If no, please explain: _____

Would you like to change the appearance of your teeth? Y / N

If yes, please explain: _____

Have you been advised of any necessary dental treatment that has not yet been treated? Y / N

Check if you have any of the following:

- Do your gums bleed while brushing or flossing?
- Are your teeth sensitive to hot, cold, sweet, or sour foods or liquids?
- Do you feel pain in any of your teeth?
- Have you noticed loosening of any of your teeth?
- Does food tend to get caught between your teeth?
- Do you have any sores or lumps in or near your mouth?
- Do you clench or grind your teeth while awake or asleep?
- Have you had any head, neck, or jaw injuries?
- Have you ever had any difficult extractions or prolonged bleeding?
- Have you ever had an upsetting dental experience?
- Do you bite your lips or cheeks frequently?
- Do you wear dentures or partials?
- Do you experience dental anxiety?

Have you ever had:

- Orthodontics (braces)
- Oral Surgery
- Periodontal or Gum Treatment
- Bite Adjustments

Have you ever experienced the following jaw problems?

- Clicking
- Pain of the joint, ear, or side of the face
- Difficulty chewing
- Difficulty opening or closing

Informed Consent of Dental Treatment

Dentistry to be Performed:

I consent to allow the doctor and/or clinical staff to obtain all necessary diagnostic information, such as radiographs (x-rays), as needed in order to reach a diagnosis of my condition. I understand that the doctor will visually examine my mouth and I will be asked to review all benefits, pertinent risks and alternatives to proposed treatment. My financial responsibility will be identified and I acknowledge that it will be my responsibility to pay these fees when treatment is started. My signature on the treatment will be acknowledgement that all this information has been presented to me, that I understand that proposal and that I consent to start treatment as listed.

Initial _____

Changes During Treatment:

I understand that during treatment it may be necessary to change or add procedures because of conditions that were not evident during the initial examination. If such change or addition should occur, the doctor will discuss the benefits, pertinent risks and alternatives, then ask for my initials or signature and date as consent of the changes prior to continuing.

Initial _____

Anesthesia or Medication:

I understand that I may require injections of local anesthesia, the use of nitrous oxide, or may be prescribed antibiotics or analgesics. These medications can cause unusual or allergic reactions including, but not limited to, nausea, swelling, pain, itching, tissue irritation, respiratory problems, prolonged muscle soreness, prolonged numbness of the lips or tongue, accidental tongue or lip biting while numb, or drowsiness. If I suffer any of these symptoms I will contact the doctor immediately for evaluation of my symptoms. I do voluntarily assume the possible hazards and risks as mentioned above and any possible side effects not mentioned and do agree to hold harmless the doctors and staff.

Initial _____

Basic Restorations (Fillings):

I understand that if my insurance carrier provides a lesser alternate benefit for silver amalgam restorations, I will be responsible for the difference between the silver amalgam and the composite resin restoration fee if I choose to have composite fillings instead of amalgam.

Initial _____

Crowns, Bridges, and Cosmetic Procedures:

With a crown preparation, I understand that I will leave wearing a temporary crown, which may come off easily and that I must be careful to ensure that it stays on until the permanent crown is cemented. I will be shown the final restoration before it is permanently installed. If I wish to have any changes, I must inform the doctor prior to cementation or give consent for the permanent cementation of the restoration. If I choose porcelain or bonded acrylic restorations, which are subject to chewing forces, I understand that the restoration may fracture or prematurely wear down my opposing teeth and that the doctor will not be responsible for any of these consequences and that it will be my responsibility to pay additionally for any rendered subsequent services. I understand that once I have accepted the final restoration and the doctor has permanently cemented it, any further changes or replacement will be at an additional expense. I understand that the potential complications include but are not limited to: nerve death of the tooth which would necessitate root canal treatment or tooth extraction, recession of the gum tissue surrounding the tooth which may create an adverse cosmetic result, and the inability to match the color or shape of the adjacent or opposing teeth.

Initial _____

Patient Signature (or Parent/ Guardian if minor) _____ Date _____

Office, Dental Insurance, and Financial Policies

Thank you for choosing Manik R. Khisti, DMD, PLLC for your dental needs. We would like to acquaint you with our policies regarding dental insurance, schedule changes, etc. We always strive to maintain quality dentistry with compassion in a comfortable and friendly atmosphere. We hope that you and your family feel welcome.

Since we know it is not always possible to pay your dental bill in full, we would like to explain our financial options. Payments may be made by cash, check, VISA, MasterCard, Discover, or American Express. There is a $35 fee for any returned checks.

As a courtesy to you, if you have dental insurance, we will file electronically with all necessary information to submit your claim to the insurance company. We do our best to provide you with as accurate a co-pay as we can based on the information provided, but it is only an estimate. We ask that you pay the estimated copayment at the time services are rendered. Once we submit the claim, the amount may vary and you will be responsible for the difference.

If you need to make arrangements for a payment plan, we offer financing through Care Credit for long-term payments or you may speak with the office manager to make arrangements for lesser expenses.

For separated or divorced parents, our policy is that the parent who brings the child to the office for treatment is responsible for payment that day.

All patients with an outstanding balance will receive a statement each month. We reserve the right to apply a billing charge of 2% per month (APR 24%) on all accounts 60 days past due.

We reserve the right to charge for broken appointments. We require 24 hours notice for most appointments, 48 hours notice for sedation appointments, and 72 hours notice for appointments scheduled on Mondays. This allows us appropriate time to offer these openings to other patients in need. The fee for a broken appointment is $50.

Significant Exposure – Section 32.1-45,1(A) and (B), code of VA (1950, as amended) provides that in the event of significant exposure (such as a needle stick), consent for testing Human Immunodeficiency Virus (HIV) and Hepatitis Virus is considered to have been given to the patient and/or healthcare worker thereby granting the Hospital the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of the local hospital.

I authorize and release information and payment of my dental insurance to the dentist. I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill including co-pays, deductibles, on non-covered services requested by me. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees at 33 1/3%, court costs, interest (and any other charges that incurred to collect this account), on the principal balance of 18% per annum from date of service.

_____ _____

Signature of Patient (or Parent/ Guardian if minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

you may refuse to sign this acknowledgement

I certify that I have received a copy of this office's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Manik R. Khisti, DMD, PLLC.

Please Print Name of Patient

Signature of Patient or Personal Representative

Description of Personal Representative's Authority

Date

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby authorize you to release my personal health information to the following individuals:

You may list as many individuals as you wish, and you may change this list at any time.

Please Print Names of Persons Authorized:

_____ _____

_____ _____

_____ _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgment

□ Other (Please Specify)

Dental Treatment Consent Form
COVID-19 Pandemic

1. The undersigned patient (the "Patient") knowingly and willingly consents to dental treatment by dentists, hygienists, technicians, and other employees of Manik R. Khisti, DMD, PLLC (the "Practice") during the COVID-19 pandemic.

2. I understand that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms, yet are still highly contagious. It is impossible to determine who carries the virus based on current limitations and availability of COVID-19 viral testing.

3. I understand that I may not be treated by the Practice if I have the COVID-19 virus or if I have been in contact with someone who has the COVID-19 virus. Therefore, I represent the following:

    A. I am unaware of any close contact with anyone who has or had the COVID-19 virus;
    B. I have not tested positive for COVID-19;
    C. I have not travelled outside the United States within the past 14 days, and I have not travelled domestically using public mass transportation, such as commercial airline, train or bus;
    D. I am not currently presenting with any of the following symptoms of COVID-19, and I have not had any of the following symptoms within the last 14 days:
        i. Fever of 100.5 degrees Fahrenheit or 37 degrees Celcius or higher;
        ii. Shortness of breath;
        iii. Dry cough;
        iv. Runny nose;
        v. Sore throat;
        vi. Diminished sense of taste and/or smell.

4. I understand that the Practice is providing its best efforts to follow CDC, OSHA, ADA, Virginia Department of Health and other professional guidelines for operation of the Practice, but that due to the nature of dental procedures, the risk of COVID-19 transmission cannot be eliminated. Dental procedures involve close personal contact and often create fine water spray, which may linger in the air for an indefinite time after a procedure. The Practice may have treated patients on an emergency basis without full screening, and other high-risk patients may have been treated by the Practice despite screening procedures. All of these factors create risk of COVID-19 transmission. Therefore, I understand that I have a higher risk of contracting COVID-19 simply by being in a dental office.

INFORMED CONSENT: I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been fully explained to me, and I have been given the opportunity to ask questions. I do voluntarily assume any and all reasonable medical/dental risks involved with my dental treatment during the COVID-19 pandemic, including the substantial and significant risk of serious harm, injury, illness, or even death.

Patient Printed Name	Signature of patient/legal guardian/ Authorized Representative	Date

Witness	Date