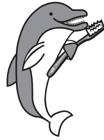

Angeli J. Thakker, D.D.S.
Bellevue Pediatric Dentistry, P.C.

Patient Information

Patient Name ____ Date ____________
Last First MI (Preferred Name)
Gender_______________ Social Security # _______________ Birth Date _______________
Name of Guardian ______________________________________ Phone (Home) ____________
Guardian (Work) _________________ Ext ________ Best time to call ___________________
(Cell) ______________________ (Emergency) _____________________________
Address ____
Street Apartment #
____
City State Zip Code

Guardian or Responsible Party Information

The following is for : ☐ the patient's guardian ☐ the person responsible for payment
Name ____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ___________
Social Security # ___________________________________ Birth Date ________________
Phone (Home) ____________ (Work) ____________ Ext ________ Best time to call __________
Address ____
Street Apartment #
____
City State Zip Code
Employer Name ______________________________________ Occupation ______________
Address____
Street City State Zip Code Phone

Insurance Information

Primary
Name of Insured ______________________________________ Insured's S.S. # ____________
Last First MI
Insured's Birth Date ______________ ID # _______________ Group # ______________
Insured's Address ____
Street City State Zip Code
Insured's Employer Name ____
Address ____
Street City State Zip Code
Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other ______________
Insurance Plan Name and Address ____
____

Secondary
Name of Insured ___________________________________ is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date ________________ ID # ________________ Group # ________________
Insured's Address ____
Street City State Zip Code
Insured's Employer Name ____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Physician ☐ Flyer ☐ Insurance Company Website ☐ Other ___________
Name of person or office referring you to our practice: ______________

CONSENT FOR TREATMENT

I hereby authorize the doctor and/or her staff to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I further authorize and consent that the doctor choose and employ such assistance as she deems fit. I understand the use of anesthetic agents embodies a certain risk.

The treatment plan has been explained to me. All questions relative to its content, necessity and scope including alternate options have been answered to my satisfaction and I agree to it.

I understand that the responsibility for payment of dental services provided in this office for my dependents is mine, due and payable at the times services are rendered, regardless of insurance coverage, unless other financial arrangements have been made.

______________________________ Signature

________________ Date

Relation to patient: Parent / legal guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this Acknowledgement*

I, ______________________________, have received a copy of
(Please Print Name)

this office's Notice of Privacy Practices

______________________________ Signature

________________ Date

Relation to patient: Parent / Legal guardian

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)