Mystic Oaks Family & Cosmetic Dentistry
Prematee Sarwan DDS

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Address: _____
Street City/State Zip code

Gender: (M or F) ____ Marital Status: Single Married Divorced Widowed DOB: _____

Whom may we thank for referring you? _____ Email _____

Phone (Home) _____ Phone (Work): _____Ext: ____ Cell # _____

Best time to call _____ SS#: _____ Occupation: _____

Emergency Contact: Name_____ Address_____ Tele#_____

Insurance Information

Subscriber Name _____ SS#/ID#_____ DO**B** _____

Insurance Co. _____ Group Number _____ Phone _____

Mailing Address _____ Employer _____

Effective Date _____ Coverage: Individual ____ Spouse ____ Children _____

Responsible Party

Person responsible for the account _____ Relationship _____

Address: _____
Street City/State/Zip Code

Home Phone # _____ Work # _____ Cell # _____ Email_____

General Information.

What is the reason for this visit? _____

Last Dental Visit_____ Last Cleaning_____ Last set of X-rays_____

How frequently do you brush your teeth? _____ Do Your Gums Bleed _____

Are you Interested in **Whitening** your teeth? _____

Are you interested in **Straightening** your teeth? _____

How did you hear about us? _____

Is there any aspect of your smile or facial features which you would like to change? _____

Mystic Oaks Family & Cosmetic Dentistry
Prematee Sarwan DDS

I hereby authorize and consent to Prematee Sarwan, D.D.S. to perform any dental procedures deemed necessary for me, my minor children and family members and to release any information, including the diagnosis and records of any treatments, x rays, photographs, or examinations rendered, to my insurance company (if applicable). I hereby authorize my insurance company to pay directly to Prematee Sarwan, D.D.S., Mystic Oaks Family & Cosmetic Dentistry, any proceeds payable under the terms of my insurance policy.

I consent and agree to Prematee Sarwan, D.D.S. to be financially responsible for payment of any outstanding balance (that is not fully covered by insurance, if applicable) for all services rendered to me and my family members. If my balance is not paid on time, I understand that there will be a $35 fee added to my account each month it is delinquent.

If you are unable to keep an appointment, we ask that you kindly provide us with at least 48 hours' notice. We ask for this advance notice so that we can offer this appointment to another patient. A fee will be charged if a patient does not show up for an appointment without sufficient notice. The fee for missed or cancelled appointments within 48 hours of is $25 per every 30 minutes that you are scheduled for. When scheduling your procedure, there is a charge for half of your total responsibility for your visit. This fee is in place to reserve appropriate chair time. If you are unable to keep your procedure appointment we kindly ask that you provide us with at least 48 hours' notice. If there is not sufficient notice there is a possible loss of deposit.

I will inform Prematee Sarwan, D.D.S. of any changes in my health and I have read and understand the HIPAA Privacy Form provided for me.

I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I consent to receive calls/texts/emails from Mystic Oaks Dentistry or their service providers for my protected healthcare and other services at the phone number above, including my wireless number provided. I understand electronic communication is not always secure. I understand I may be charged for such calls/texts/emails by my wireless carrier and that such calls/texts/emails may be generated by an automated dialing system.

I hereby certify that I have read and understand all of the preceding information and that it is accurate and true to the best of my knowledge.

_____	_____	_____
Patient (Printed) Name	Date	Patient Signature