MUDGIL

PERIODONTICS AND
IMPLANT DENTISTRY

PATIENT INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:
DATE OF BIRTH:	EMAIL ADDRESS:	SS#:
ADDRESS:		APT:
CITY:	STATE:	ZIP CODE:
HOME PHONE:	WORK PHONE:	CELL PHONE:
MARITAL STATUS:	SEX:	OCCUPATION:

REFERRING PHYSICAN

REFERRING PHYSICIAN:	PHONE NUMBER:

EMERGENCY CONTACT

NAME:	PHONE:
RELATIONSHIP:	

PHARMACY INFORMATION

NAME:	PHONE:

PATIENT RELEASE

(MUST BE SIGNED BY PATIENT IF OVER 18 OR BY LEGAL GUARDIAN IF PATIENT IS UNDER 18)

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits of the provider.

I certify that I hereby authorize Dr. Vanita A. Mudgil, DDS and staff to provide my minor child in my absence with examinations and basic treatments for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedure that may require separate consent such as surgery or biopsy. I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

SIGNATURE:	DATE:

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INSURANCE INFORMATION

NAME OF INSURED:	RELATIONSHIP TO PATIENT:
DATE OF BIRTH:	SS#:

EMPLOYER NAME:		DATE EMPLOYED:
EMPLOYER ADDRESS:		CITY:
STATE:	ZIP CODE:	SUITE:

INSURANCE COMPANY:		GROUP #:
EMPLOYER ADDRESS:		CITY:
STATE:	ZIP CODE:	SUITE:

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PATIENT CONSENT

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION & WRITTEN RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby give my consent for Mudgil Dentistry to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Mudgil Dentistry's "Notice of Privacy Practices" provides a more complete description of such uses and disclosures. I have the right to review the "Notice of Privacy Practices" prior to signing this consent. Mudgil Dentistry reserves the right to revise its "Notice of Privacy Practices" at anytime. A revised "Notice of Privacy Practices" may be obtained by forwarding a written request to Mudgil Dentistry, 99 Woodbury Road, Hicksville, New York 11801

PLEASE CHECK "YES" FOR ALL ITEMS BELOW THAT YOU GIVE MUDGIL DENTISTRY PERMISSION TO PERFORM

(If any one item is a "NO" then the whole item is excluded)

With this consent, Mudgil Dentistry may:

Y N Call my home or cell phone and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory & biopsy results, among others.

Y N At any alternative location leave a message on my personal voicemail or in person in reference to any items or any calls pertaining only to my clinical care, including laboratory & biopsy results, among others. However, at any alternative location call, Mudgil Dermatology, P.C. will not leave a message about my medical condition or lab result with any other person.

Y N Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

Y N If I decide to give you my e-mail address, you may use it only to assist the practice in carrying out TPO, including appointment reminder and patient statements.

Y N Treat my minor, if they come without me, for an office visit.

I have the right to request that Mudgil Dentisty restrict how it uses and discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Mudgil Dentistry use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, or later revoke it, Mudgil Dentistry may decline to provide treatment to me. I understand that a copy of Mudgil Dentistry's "Notice of Privacy Practices" is available for my review.

SIGNATURE: DATE:

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CREDIT CARD AUTHORIZATION

It is the practice policy of Mudgil Dentistry to maintain a credit card on file for every patient to process any remaining outstanding charges you may have after your insurance company has processed your claim. This information will be held securely until your insurance carrier has paid its portion and notified us of your share. After we have received notice from your insurance company, we will charge any remaining balance to your credit card. We will mail or email you a receipt for the charge. Please note that this process will not compromise your ability to dispute a charge with your insurance carrier's determination of payment.

I, authorize Mudgil Dentistry to charge outstanding balances to the following credit card.

CREDIT CARD INFORMATION

CREDIT CARD TYPE :	ACCOUNT NUMBER :
SECURITY CODE :	EXPIRATION DATE :
BILLING ADDRESS :	
NAME ON CARD:	SIGNATURE:

99 WOODBURY ROAD HICKSVILLE, NY 11801
p 516 595 7454 • *f* 516 888 9725