Ajey Varma, D.D.S., P.L.L.C.

WWW.DRVARMA.COM
2302 S Union Ave Ste B17 • Tacoma, WA 98405-1333

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(253)752-6915

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

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

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work
☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Primary Insurance Information

The following is for:* ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name:* _____ Phone: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Primary Medical Insurance:

Name of Insured: _____ _____ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Secondary Medical Insurance:

Name of Insured: _____ _____ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Medical History/Medications/Allergies

A.I.D.S. *	◯ Yes ◯ No	Allergies or Hives *	◯ Yes ◯ No
Alzheimer's/Dementia *	◯ Yes ◯ No	Arthritis/Rheumatism *	◯ Yes ◯ No
Artificial Heart Val *	◯ Yes ◯ No	Artificial Joints *	◯ Yes ◯ No
Asthma *	◯ Yes ◯ No	Blood Disease *	◯ Yes ◯ No
Blood Transfusion *	◯ Yes ◯ No	C.O.P.D. *	◯ Yes ◯ No
Cancer *	◯ Yes ◯ No	Chemotherapy *	◯ Yes ◯ No
Chronic Cough *	◯ Yes ◯ No	Clotting Disorder *	◯ Yes ◯ No
Cold Sores/Fever Bli *	◯ Yes ◯ No	Cong. Heart Disease *	◯ Yes ◯ No
Cortisone Medicine *	◯ Yes ◯ No	Diabetes *	◯ Yes ◯ No
H.I.V. Positive *	◯ Yes ◯ No	Heart - Afib *	◯ Yes ◯ No
Heart Murmur *	◯ Yes ◯ No	Heart Pacemaker *	◯ Yes ◯ No
Heart Problems *	◯ Yes ◯ No	Heart(Surg/Dis/Atck) *	◯ Yes ◯ No
Hemophilia *	◯ Yes ◯ No	Hepatitis A *	◯ Yes ◯ No
Hepatitis B *	◯ Yes ◯ No	High Blood Pressure *	◯ Yes ◯ No
Jaw Pain *	◯ Yes ◯ No	Latex Sensitivity *	◯ Yes ◯ No
Mitral Valve Prolasp *	◯ Yes ◯ No	Nervous/Anxious *	◯ Yes ◯ No
Pre-med Needed *	◯ Yes ◯ No	Radiation Therapy *	◯ Yes ◯ No
Rheumatic Fever *	◯ Yes ◯ No	Sleep Apnea *	◯ Yes ◯ No
Stroke *	◯ Yes ◯ No	TMD *	◯ Yes ◯ No
Tobacco Habit *	◯ Yes ◯ No	Xerostomia-Dry Mouth *	◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

Do you have any allergies? ◯ Yes ◯ No

If yes, please list below.

_____

_____

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

Response Date: _____

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Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Consent for Treatment

I understand the information given is correct and will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in the patient's medical status. I hereby authorize this office to perform an oral evaluation and consent to the taking of x-rays, photographs and other records (if necessary) to determine appropriate treatment on the above-named patient.

Consent for Internet Communications

I authorize this office to leave messages about appointments on my voice mail or answering machine, and agree to receive e-email and text messages regarding billing statements and upcoming appointments.

Financial Policy

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance. Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan. Copays are due at the time of service. Coinsurance, deductibles, and non-covered items are due 30 days from receipt of billing unless otherwise arranged. Patients may incur, and are responsible for payment of Charge for returned checks - $35.00

I hereby authorize assignment of financial benefits directly to Ajey Varma, D.D.S., P.L.L,C. I understand that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collection of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release the information necessary to secure the payment of benefits.

HIPAA Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a HIPAA or the Healthcare Privacy Act). I understand that by signing this consent, I authorize This Office to use and/ or disclose my protected healthcare information to carry out the following:

- Treatment which includes direct and/ or indirect treatment by my other healthcare providers involved in my treatment.

- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.

- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses of disclosures of my protected health information, and my rights under HIPAA. I understand that your reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do not agree, you are bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Dependent family members also covered by HIPAA Patient Consent, please list here: _____

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient: _____

Response Date: _____