LIC Dental ASSOCIATES
Advanced Family & Cosmetic Dentistry

2721 Jackson Ave
Long Island City, NY 11101

T: 718.280.3286
E: QueensPlaza@licdentalassociates.com
W: licdentalassociates.com

Dear Patient,

Please allow me to welcome you into the LIC Dental Associates family! We are honored that you have chosen us to care for your oral health needs and look forward to becoming your partner in health.

Our office emphasizes early preventive care for you and your family. We also provide comprehensive dental care including restorative care, cosmetic dentistry, Invisalign, periodontal care and emergency services.

With this in mind, let me tell you what you can expect on your first visit to our office.

Patients are treated as guests at our practice. You'll meet our highly-trained staff members and a doctor who will spend time listening to your concerns. Our priority is to educate you on your current oral health status and to help you meet your oral health goals.

During your first visit, we'll perform a comprehensive examination as part of your oral hygiene appointment. This includes necessary x-rays, allowing us to diagnose the condition of your mouth, teeth and gums. We will also provide screenings to check for signs of gum disease and oral cancer. In most instances, your oral health status will be determined at this visit, and if needed, a suitable treatment plan will be discussed with you.

You can explore our full list of services on our website at www.licdentalassociates.com. Enclosed, you will find our registration and health history forms. Please follow the instructions to submit these directly to our office.

Should you have any questions or requests to make your visit more pleasant, please call our office at 718-530-6539 or email me at dr.saran@licdentalassociates.com.

We look forward to meeting you and serving your dental needs.

Sincerely,
Dr. Ishwinder Saran, DMD, AEGD
LIC Dental Associates

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PATIENT REGISTRATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

CONTACT DETAILS

Patient name: _____ Date of birth: _____Sex: M □ F □

Home Address: _____ City: _____ State: ____ Zip: _____

Billing Address (if different): _____ City: _____ State: ____ Zip: _____

Employer: _____ City: _____ State: ____ Zip: _____

Cell phone number: _____ Work number: _____

Email: _____ Preferred method of contact: Phone □ Text □ Email □

Emergency contact name: _____ Emergency contact phone number: _____

Referred by: ZocDoc □ Yelp □ Google □ Patient □_____ Other □ _____

INSURANCE DETAILS

Primary dental insurance company: _____ Subscriber name: _____

Subscriber date of birth: _____ Group #: _____ Policy ID #: _____

Subscriber employer: _____ Subscriber Social Security #_____

Secondary dental insurance company : _____ Subscriber name: _____

Subscriber date of birth: _____ Group #: _____ Policy ID #: _____

Subscriber employer: _____ Subscriber Social Security #_____

MEDICAL HISTORY

Primary physician name: _____

Primary physician phone #: _____

Date of last visit: _____

Reason for last visit: _____

_____

Describe your current general health status:
Excellent □ Good □ Fair □ Poor □

ALLERGIES: Do you or have you had an allergy to any of the following?

- aspirin, ibuprofen Y○ N○
- acetaminophen Y○ N○
- codeine Y○ N○
- penicillin Y○ N○
- erythromycin Y○ N○
- tetracycline Y○ N○
- sulfa Y○ N○
- local anesthetic Y○ N○
- metals (nickel, silver, etc.) Y○ N○
- latex Y○ N○
- Other: _____

PREMEDICATION: Do you require antibiotic premedication for the following conditions: artificial heart valve, history of ineffective endocarditis, repaired or unrepaired congenital (present from birth) heart disease or presence of artificial joints? Y○ N○

WHAT HAVE YOU BEEN PRESCRIBED FOR PREMEDICATIONS IN THE PAST:

_____

MEDICATIONS: Have you taken any of the following medications in the past six months?

- nitroglycerine Y○ N○
- bisphosphonates Y○ N○
- blood thinners Y○ N○

LIST OF CURRENT MEDICATIONS:

_____

_____

_____

Do you or have you had any of the following?

1. Heart conditions:
   - chest pain, heart attack Y○ N○
   - pacemaker or defibrillator Y○ N○
   - high blood pressure Y○ N○
   - other _____
2. Blood conditions:
   - anemia Y○ N○
   - easy bruising & bleeding Y○ N○
   - others _____
3. Lung conditions:
   - emphysema, shortness of breath Y○ N○
   - TB, asthma Y○ N○
   - other _____
4. GI / Digestive tract conditions:
   - stomach ulcers Y○ N○
   - others _____
5. Infectious conditions and STI:
   - HIV / AIDS Y○ N○
   - hepatitis Y○ N○
   - herpes / cold sores Y○ N○
   - other _____
6. Endocrine conditions:
   - thyroid, parathyroid disease, or calcium deficiency Y○ N○
   - diabetes Y○ N○
   - osteoporosis/osteopenia Y○ N○
6. Autoimmune conditions:
   - rheumatoid arthritis, lupus Y○ N○
   - others _____
7. Neurological conditions:
   - epilepsy, convulsions (seizures) Y○ N○
   - Stroke Y○ N○
   - other _____
8. Psychiatric conditions: Y○ N○
   - depression Y○ N○
   - other _____
8. Cancer, radiation or chemotherapy? Y○ N○
9. Do you smoke? Y○ N○
   How many packs per week _____
10. Do you drink alcohol? Y○ N○
    How many drinks per week _____

WOMEN ONLY:

- Are you pregnant? Y□ N□
- Are you nursing? Y□ N□
- Oral contraceptives? Y□ N□

DENTAL HISTORY

Previous dentist name: _____

Previous dentist phone #: _____

Date of last dental exam: _____

Date of last dental x-rays: _____

Describe your current dental health status:
Excellent ◯ Good ◯ Fair ◯ Poor ◯

How often do you brush your teeth in a day?
Once ◯ Twice ◯

How often do you floss you teeth?
Daily ◯ Occasionally ◯ Never ◯

Please describe in your own words the reason for your visit today:
_____
_____
_____
_____
_____

Are you in any pain today? Y ☐ N ☐

On a scale of 1-10 , please rate your pain _____

Have you noticed any swelling in your mouth?

Y ☐ N ☐

GENERAL DENTAL ASSESSMENT:

1. Are you fearful of dental treatment? Y ☐ N ☐
   How fearful, on a scale of 1 (least) to 10 (most) [____]
2. Have you had an unfavorable dental experience? Y ☐ N ☐
3. Have you ever had complications from past dental treatment? Y ☐ N ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? Y ☐ N ☐

GUMS AND BONE ASSESSMENT:

5. Do your gums bleed or are they painful when brushing or flossing? Y ☐ N ☐
6. Have you ever been treated for gum disease or been told of bone loss around your teeth? Y ☐ N ☐
7. Have you ever noticed an unpleasant taste or odor in your mouth? Y ☐ N ☐
8. Is there anyone with a history of periodontal disease in your family? Y ☐ N ☐
9. Have you ever experienced gum recession? Y ☐ N ☐
10. Have you ever had any teeth become loose on their own (without an injury)? Y ☐ N ☐
11. Have you experienced a painful sensation in your mouth not related to your teeth? Y ☐ N ☐

TOOTH HEALTH ASSESSMENT:

12. Have you had any cavities within the past 3 years? Y ☐ N ☐
13. Does the amount of saliva in your mouth seem too little? Y ☐ N ☐
14. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? Y ☐ N ☐
15. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? Y ☐ N ☐
16. Do you have grooves or notches on your teeth near the gum line? Y ☐ N ☐
17. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? Y ☐ N ☐
18. Do you frequently get food caught between any teeth? Y ☐ N ☐

BITE AND JAW JOINT ASSESSMENT:

19. Do you have problems with your jaw joint (pain, sounds, limited opening, popping)? Y ☐ N ☐
20. Have your teeth changed in the last 5 years, become shorter, thinner or worn? Y ☐ N ☐
21. Are your teeth becoming more crooked, crowded, or overlapped? Y ☐ N ☐
22. Are your teeth developing spaces or becoming more loose? Y ☐ N ☐
23. Do you chew ice, bite your nails, or have any other oral habits? Y ☐ N ☐
24. Do you clench your teeth in the daytime or make them sore? Y ☐ N ☐
25. Do you wake up with a headache or an awareness of your teeth? Y ☐ N ☐
26. Have you or has your partner noticed you grinding your teeth at night? Y ☐ N ☐
27. Do you wear a night guard or have been recommended one in the past? Y ☐ N ☐

SMILE CHARACTERISTICS:

28. Is there anything about the appearance of your teeth that you would like to change? Y ☐ N ☐
29. Do you have crooked, crowded, spaced or misaligned teeth? Y ☐ N ☐
30. Have you ever thought about whitening your teeth? Y ☐ N ☐
32. Have you felt uncomfortable or self conscious about the appearance of your teeth? Y ☐ N ☐
33. If you could change your smile, what would you change?

☐ Remove unsightly fillings ☐ Straighten teeth ☐ Change shape of teeth
☐ Whiter teeth ☐ Replace missing teeth ☐ Make teeth same color
☐ Close gaps between teeth ☐ other _____

Is there anything else that you would like to discuss with the dentist about your oral health needs? Y ☐ N ☐

_____

MEDICAL / DENTAL HISTORY CONSENT

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify LIC Dental Associates of any changes at any subsequent appointment.

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Patient's Signature _____ Date _____
Hygienist / Assistant Name and Signature _____ Date _____
Doctor's Name and signature _____ Date _____

HIPAA CONSENT

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

Section A: Patient Giving Consent
Patient Name: _____

SECTION B: PATIENTS PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

NOTICE OF PRIVACY PRACTICES: you have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice is available at your request in our office. We encourage you to request a copy and read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Dr. Ishwinder Saran
LIC Dental Associates
Address: 2721 Jackson Ave, Long Island City, NY 11101

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by providing our office with a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

CONSENT: I, the patient and/or representative, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Signature: _____ ***Date:***_____

****If this Consent is signed by a personal representative on behalf of the patient, please complete the following:***
Personal Representative Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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SCHEDULING POLICY

Our practice is dedicated to quality care and exceptional service. We value our patients and their time. Continuity and consistency of care are key to maintaining proper dental health.

Our doctors and team spend extensive amounts of time preparing for your visit. **Your appointment is reserved exclusively for you**; therefore a courtesy of a **minimum of 48 business hours advance notice** when you are unable to keep an appointment is appreciated and required. We also require that you call our office to reschedule or cancel an appointment in the event that an email, voice mail, or text message may be overlooked. **If proper notice is not received, a fee of $50.00 will be charged to your credit card on file.**

If two or more appointments are missed, canceled or changed in a twelve month period without 48 business hours notice all future appointments will be canceled and you will be placed on a "standby list" for your next visit.

We reserve the right to dismiss any patient from the practice who misses, cancels or changes three or more consecutive appointments without 48 business hours notice. Furthermore, patients who consistently change appointments with or without notice may be subject to dismissal.

We request that you **arrive 10 minutes early** to your reserved appointment time to facilitate any paperwork, payments or processing that you may need. We strive to be prompt in seeing patients at their reserved time. If you are **more than 15 minutes late for your appointment, the doctor may ask that you be rescheduled to allow for the proper time needed for your procedure**. If you are more than 15 minutes late and we are not able to accommodate you, **we will consider this to be a missed appointment.**

I have read and agree to the Cancellation Policy of LIC Dental Associates. I agree to a credit card on file that will be automatically charged for violation of these policies or upon notification for services rendered.

Patient Name _____ Signature _____ Date _____

LIC Dental ASSOCIATES
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FINANCIAL POLICY

We accept **most PPO and Union Plans**. We also offer our own **in house dental insurance plan**. Our friendly staff will be happy to help you maximize dental benefits. We can help you verify your dental insurance coverage and benefits prior to you arriving at the office. Therefore, please fill out all necessary insurance information prior to your first visit. That way, we'll be able to save you time and give you a closer estimate on your portion of the fee for each visit. **Most plans only cover part of your dental treatment. Many dental insurance policies have exclusions and limitations that can affect your out-of-pocket cost.**

As a courtesy to our insured patients, **we will be happy to help file your dental insurance claims**. However, please remember that **your dental insurance policy is a contract between you, your employer and the insurance company. We are not a party to this contract and do not directly contract with insurance companies.** Therefore, **any payment that is not received from your insurance after 60 days from the treatment day will be due in full from you**. You will then have to obtain reimbursement directly from your insurance company. Please understand that we cannot accept responsibility for collecting your insurance claim or for negotiating disputed claims between you and your insurance company. There will be a finance charge of 1.5% per month applied on all account balances after 90 days.

We ESTIMATE your co-payments and deductibles to the best of our knowledge at the time of service. **This payment is due at the time of service.** This estimate is based on your insurance's fee schedule, our fee schedule and your coverage type. The balance that you owe is subject to change once we receive payment from your insurance carrier. **You will receive a check for any overpayments and an invoice due for any underpayments.**

OTHER PAYMENT METHODS / PAYMENT PLANS
We accept the following forms of payment: **Cash, Check, Visa and MasterCard.** In addition, we also offer third party **payment plans** (care credit, etc.) and **in office financing** for certain treatments as well as our own **in house dental insurance plan**. Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee.

Payment for services including estimated co-payments are due at the time services are rendered unless prior arrangements have been made. Any balances remaining that are less than $50.00 after insurance has been processed and received will be automatically billed to your credit card on file. Any balance more than $50.00 will be invoiced to you and will be due upon receipt of your statement.

I have read and agree to the Financial Policy of LIC Dental Associates.

Patient Name: _____ Signature: _____ Date: _____

LIC Dental ASSOCIATES
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INSURANCE POLICY

We accept **most PPO and Union Plans**. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. If you are planning on using your dental insurance please read the following dental insurance facts.

FACT 1 – DENTAL INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. Please note that we accept most major PPO plans **BUT WE DO NOT DIRECTLY CONTRACT WITH THEM.** This means that **AS A COURTESY** we will process your insurance benefits and accept assignment of benefits if your plan allows it. We will also file the claim on your behalf and wait for insurance portion of your visit to be paid directly to our office by the insurance company.

FACT 2 – DENTAL INSURANCE IS NOT MEANT TO COVER ALL FEES. Most insurance companies will help cover preventive services up to 100%. Most basic, restorative and surgical services are covered between 50-90% depending on your plan.

FACT 3 – NO INSURANCE PAYS 100% OF ALL PROCEDURES. Many patients think that their insurance pays 90%-100% of all dental fees. Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer have paid for coverage or the type of contract your employer has set up with the insurance company.

FACT 4 – FREQUENCIES & LIMITATIONS OF BENEFITS. The frequency of payment for some procedures may be limited by an insurance company. This is most often encountered with x-rays and fluoride treatments. Our office follows recommendations set by the ADA and the FDA in order to achieve optimal oral health for you. Therefore, if an insurance plan limits the frequency of such codes, the patient will be responsible for the fees involved.

FACT 5 – BENEFITS ARE NOT DETERMINED BY OUR OFFICE. Not all insurance companies are the same and not all plans administered by a particular insurance company are the same. It is important to understand the type and frequency of benefits that your particular insurance plan provides.

FACT 6 – DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED. When estimating dental benefits, deductibles and percentages must be considered. To illustrate, assume the fee for service is $150.00. Assuming that the insurance company allows $150.00 as its usual and customary (UCR) fee, we can figure out what benefits will be paid. First a deductible (paid by you), on average $50, is subtracted, leaving $100.00. The plan then pays 80% for this particular procedure. The insurance company will then pay 80% of $100.00, or $80.00. Out of a $150.00 fee they will pay an estimated $80.00 leaving a remaining portion of $70.00 (to be paid by the patient). Of course, if the UCR is less than $150.00 or your plan pays only at 50% then the insurance benefits will also be significantly less. **YOU WILL BE RESPONSIBLE FOR YOUR ESTIMATED COPAYS AT THE TIME OF SERVICE, ANY BALANCES REMAINING AFTER INSURANCE HAS BEEN PROCESSED ARE THE PATIENT'S RESPONSIBILITY**.

I have read and understand the facts presented above. I also have read and understand my insurance policy and the coverage benefits that it provides at LIC Dental Associates. I also understand that any balances remaining that are less than $50.00 after insurance has been processed and received will be billed automatically to my credit card on file. Any balances of more than $50.00 will be invoiced to me and will be due upon receipt.

Patient Name: _____ Signature: _____ Date: _____

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RADIOLOGY POLICY

X-Rays provide one of the best diagnostic tools in dentistry. They enable the dentist and hygienist to see inside the tissue of the teeth, gums and bones of the jaw. X-rays are the only way to diagnose bone loss, cavities between teeth and root tip infections that require endodontic (root canal) treatment.

If you are new to our practice we require a full mouth series of x-rays to determine your dental health and formulate a treatment plan if necessary. If you have been seen by a dentist within the last six months and have had x-rays taken you can have them forwarded to our office. If they are dated with in six months and of good quality, it may not be necessary take new x-rays at your first visit with us. If no x-rays have been taken, or if the ones forwarded to us are not of diagnostic quality, or if we do not receive the x-rays before your visit we will need to take new diagnostic x-rays at our office. We can prescribe additional x-rays as needed for diagnosis at your initial visit after you have consulted with the dentist.

We assure you that **we are conservative in our use of x-rays**, but without them, decay and other diseases of the teeth and mouth often cannot be diagnosed until serious damage has been done. **We base our decision to take X-rays on the recommendations of the ADA and the FDA as well as the standard of care as defined in NY and the United States.** These guidelines, developed by the ADA and FDA stress **individualized radiographic examination**. Meaning that each patient and their oral health status is unique and **X-rays are prescribed by the dentist once the dentist has assessed the patients health and dental history as well as current oral health status at their initial and recall visits**. Some patient may require bitewing x-rays every six months, where as others may require them every twelve months or more.

We use the **Nomad Handheld X-ray system**, which employs substantially **less radiation** than other digital x-rays systems, and traditional wall mounted units. We also use the latest **digital sensor** that needs only a fraction of exposure time compared to older digital sensors and traditional film. As a result we have **significantly reduced the exposure** to our patients and staff.

You can refuse any diagnostic test or treatment. However, **doctors cannot provide care for patients based on an incomplete diagnosis** without becoming subject to liability for failure to diagnose or treat existing conditions. Some dental insurance plans have limits on their coverage of radiographs. **You may be responsible for the fees involved, as insurance may not cover these. I have reviewed LIC Dental Associates radiology Policy.**

Patient Name: _____ Signature: _____ Date:_____

Form complete!
(Now that wasn't so bad, was it?)

In-Office Patients -- Please return this form to reception.
We'll be with you shortly.