

PATIENTINFORMATION

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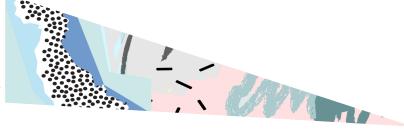
LastName:	First Name:	MI:
Preferred Name:	DOB://	,
If there are any changes to your p	ersonal info, please note o	changes below
ADDRESS:		
CITY: STATE: _		
Email:		
Phone: (please √ preferred) □ cell: _		
SOCIAL NETWORKING *option	eal.	
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*follow us @ninakumardds for news & updates!



New Insurance? Please provide details below:

PATIENT IS: Patient Responsible Party	Policy Holder	
Have you used this insurance before today? [□ YES □ NO	
Relationship to Policy Holder:		
Policy Holder (if not self):		
First Name: Last Name:	MI:	_
Policy Holder's DOB ://	SS#:	
Primary Insurance:	Policy #:	
Employer:		
Secondary Insurance:	Policy #:	
Relationship to Policy Holder:		
Last Name: First Name:	MI:	
Policy Holder's DOB(if not self): / /	SS#:	



HEALTHUPDATE

111111	Are there any changes in your health?	☐ YES ☐ NO if yes, please explain:		
Ш	Are you taking any new medications?	☐ YES ☐ NO if yes, please explain:		
	Do you have any new dental issues or concerns?	☐ YES ☐ NO if yes, please explain:		THE PROPERTY OF THE PARTY OF TH
	Do you have any discomfort at this time?	☐ YES ☐ NO if yes, please explain:		
Additi	ional comments/conce	rns:		
better tr	eat you. This includes, but in, recent surgeries, emerg	t is not limited to, cha	all changes in your health so that we can nges in your medications, visits to your newly discovered medical problems, etc.	
Signatu	re:		Date:/	
Name:				



Here at the office of Dr. Nina Kumar, we do understand that in today's world, occasionally situations come up that are beyond your control. Keeping this in mind, we are asking that you extend the courtesy of adequate time to reschedule valuable appointment time that was reserved just for you. If you know that there may be an issues with your appointment time, the sooner you contact our office, the more effective we can be in allowing other patients the opportunity to fulfill their treatment needs. We ask that you give us 24 hour notice for appointments scheduled for an hour (or less) in duration, and an additional 24 hours (48 hours) for appointments in excess of an hour.

For individuals that do not comply with this request will be required to pay a cancellation fee of \$150.

Chronic abusers of scheduled appointments and patients who have scheduling issues due to personal &/or work conflicts will be placed on the ASAP list and will be contacted as availabilities arise in the schedule.

By signing below, you are agreeing to the terms of this policy and understand and accept them.

Signature:	Date://
Name:	