NINA KUMAR DDS

patientinfo

PATIENT**INFORMATION**

LastName: _____ **First**Name:_____**MI**:_____

PreferredName: _____ DOB: ___/____/_____

✶If there are any changes to your personal info, please note changes below✶

ADDRESS: _____

_____

CITY: _____ STATE: ____ ZIP: _____

Email: _____

Phone: (please ✓preferred) ☐ cell: ___-____-_____ ☐ work: ___-____-_____

SOCIAL**NETWORKING** **optional*

@ _____

@ _____

**follow us @ninakumardds for news & updates!*

NINA KUMAR DDS

insuranceinfo

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#: ____-____-_____

HEALTH**UPDATE**

Are there any changes in your health? ☐ YES ☐ NO
if yes, please explain: _____

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: _____

Do you have any discomfort at this time? ☐ YES ☐ NO
if yes, please explain: _____

Additional comments/concerns:

_____

_____

_____

_____

Please be advised: It is imperative that you share any & all changes in your health so that we can better treat you. This includes, but is not limited to, changes in your medications, visits to your physician, recent surgeries, emergency hospital visits, newly discovered medical problems, etc. Thank you!

Signature: _____ Date: ____/____/_____

Name: _____

NINA KUMAR DDS

CANCELLTIONPOLICY

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: _____