Ajay Gulati B.D.S., M.S., P.A.

Rockwall-Heath Endodontics
3018 Ridge Road,
Suite 100-Rockwall, TX 75032

Endodontic Associates of East Texas
3101 Joe Ramsey Blvd E
Suite 103-B-Greenville, TX 75401

Ph:469-698-8282 Fax:469-402-2600

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Name: _____Prefer to be called _____ Sex:_____

If under 18: Parent/Guardian Name_____Relationship_____

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

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Age:_____ Social Security _____-_____-_____ Birth date:_____

Dentist's Name:_____ E-mail:_____

Do you know a patient currently in our practice? If so, whom: _____

What concerns you most about endodontic treatment?

□discomfort □anxiety □cost □length of treatment □other_____

Whom may we thank for referring you to our office?_____

EMPLOYMENT INFORMATION

Employer: _____

Occupation_____

Address_____City_____Zip Code_____

WK. Phone _____ How long with this employer? _____

FAMILY AND ACCOUNT INFORMATION

Spouses Name:_____Employer_____WK. Phone_____

Person responsible for account: _____

If other than self or spouse:

Name: _____ Relationship:_____

Address: _____Phone:_____

EMERGENCY INFORMATION

In case of an emergency, please provide name, address and phone number of your nearest relative:

Name: _____ Relationship_____

Address:_____Phone: _____

INSURANCE INFORMATION

If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of insured: Employee:_____Relationship_____

Employer:_____

Date of Birth: _____Social Security#_____-_____-_____

Name of insurance company: _____Group #: _____

Ajay Gulati, B.D.S., M.S., P.A. and associates

HEALTH QUESTIONNAIRE FOR: _____

PHYSICIAN_____

ADDRESS _____ CITY _____ PHONE _____

YOUR AGE _____ HEIGHT _____WEIGHT _____ MO/YEAR OF YOUR LAST MEDICAL EXAMINATION _____

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH (CIRCLE ONE): EXCELLENT GOOD FAIR POOR DON'T KNOW

YES	NO	???	
❑	❑	❑	HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?
❑	❑	❑	HAVE YOU HAD A SERIOUS ILLNESS, OPERATION OR HOSPITALIZATION DURING THE PAST FIVE YEARS?
			IF YES, PLEASE DESCRIBE _____
❑	❑	❑	ARE YOU TAKING OR HAVE YOU RECENTLY TAKEN ANY OF THE FOLLOWING:
			PRESCRIBED MEDICATIONS & INHALERS: _____
			OVER THE COUNTER, NATURAL OR HERBAL PREPARATIONS:_____
❑	❑	❑	HAVE YOU EVER ❑ RECEIVED I.V., OR ❑ TAKEN ORALLY: AREDIA, ZOMETA , FOSAMAX OR ANY OTHER BISPHOSPHONATES ?
❑	❑	❑	HAVE YOU EVER TAKEN PONDIMIN (FENDLURAMINE) , PHEN–FEN (PHENTERMINE) OR REDUX (DEXPHENFLURAMINE) FOR WEIGHT REDUCTION?
❑	❑	❑	HAS YOUR M.D. TOLD YOU TO TAKE ANTIBIOTICS PRIOR TO HAVING ANY TYPE OF DENTAL PROCEDURE?
❑	❑	❑	ARE YOU ALLERGIC TO ANY MEDICATIONS OR DRUGS, LATEX, IODINE? _____
❑	❑	❑	HAVE YOU EVER HAD ADVERSE REACTION TO ANY DRUGS, ANESTHETICS, SEDATIVES, NARCOTICS, ASPIRIN, IBUPROFEN (MOTRIN)?
❑	❑	❑	HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT?
❑	❑	❑	HAVE YOU BEEN DIAGNOSED AS HAVING ANY IMMUNODEFICIENCY, SYSTEMIC LUPUS, ARC OR AIDS?
❑	❑	❑	IS THERE A HISTORY OF DIABETES IN YOUR FAMILY?
❑	❑	❑	ARE YOU REQUIRED, DUE TO HEALTH, TO RESTRICT YOUR WORK OR ACTIVITY IN ANY WAY?
❑	❑	❑	ARE YOU ON A SPECIAL OR RESTRICTED DIET OF ANY KIND? _____
❑	❑		DO YOU USE ANY KIND OF TOBACCO? IF SO HOW MUCH: _____ PER DAY, WEEK, MONTH
❑	❑		DO YOU USE ANY KIND OF ALCOHOL? IF SO HOW MUCH: _____ PER DAY, WEEK, MONTH
❑	❑	❑	DO YOU HAVE ANY HISTORY OF SUBSTANCE ABUSE OR DO YOU CURRENTLY USE RECREATIONAL DRUGS?

FOR WOMEN, CHECK ALL THAT ARE APPROPRIATE: ❑ I AM PREGNANT ❑ I AM NURSING ❑ I AM TAKING BIRTH CONTROL PILLS

CHECK ALL OF THE FOLLOWING THAT YOU MAY HAVE HAD IN THE PAST OR THAT CURRENTLY APPLY TO YOU:

❑CHEST PAIN UPON EXERTION	❑RECEIVED BLOODTRANSFUSION	❑SLEEP APNEA	❑HEADACHES
❑SHORTNESS OF BREATH	❑IMPAIRED LIVER FUNCTION	❑ASTHMA	❑MIGRAINES
❑HIGH BLOOD PRESSURE	❑KIDNEY DISEASE	❑BRONCHITIS	❑EPILEPSY
❑LOW BLOOD PRESSURE	❑IMPAIRED KIDNEY FUNCTION	❑EMPHYSEMA	❑SEIZURES
❑HEART VALVE PROSTHESIS	❑ESOPHYGEAL REFLUX	❑SINUS TROUBLES	❑MENTAL HEALTH PROBLEMS
❑MITRAL VALVE PROLAPSE	❑HIATAL HERNIA	❑PERSISTENT COUGH	
❑CONGENITAL HEART LESION	❑G.I. ULCERS	❑TUBERCULOSIS	❑GLAUCOMA
❑RHEUMATIC FEVER	❑ANOREXIA OR BULEMIA		❑WEAR CONTACT LENSES
❑HEART MURMUR	❑IRRITABLE BOWEL SYNDROME	❑JOINT REPLACEMENT SURGERY	❑SEVERELY IMPAIRED VISION
❑DAMAGED HEART VALUE	❑ COLITIS	❑ARTHRITIS	
❑HEART ARRTHYMIIA	❑ DIABETES	❑CONNECTIVE TISSUE DISORDER	❑RECURRENT INFECTIONS
❑TACHYCARDIA		❑OSTEOPOROSIS	❑CHRONIC FATIGUE
❑HEART SURGERY	❑RADIATION THERAPY		❑RECENT WEIGHT LOSS
❑CARDIAC PACEMAKER	❑CHEMOTHERAPY	❑NEUROLOGICAL DISORDERS	
❑HEPATITIS OR JAUNDICE	❑HISTORY OF CANCER	❑STROKE	

Do you have any disease, problem or condition not listed above? Please explain: _____

_____

_____ _____ _____

Signature of patient or legal guardian Date Reviewed by

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by the applicable laws. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we make the changes. Before we make a significant change in our privacy practices, we will change the Notice and make a new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations: For example:

Treatment: We may use or disclose your health information to a dentist, physician, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provide performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the patient Rights sections of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Persons Involved In Care: We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures.

In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Ajay Gulati, B.D.S., M.S., P.A. and associates

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

I have been informed that this practice will make reasonable effort to protect the privacy of my health information in accord with the policies set down for dental care providers under the Health Insurance Protection and Accountability Act of 1996 and have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release of any and all medical and dental information pertinent to my treatment to my other treating healthcare providers. I approve the office of Ajay Gulati, B.D.S, M.S, P.A. to discuss my health information with the following_____ (i.e. spouse/partner, parent, relative, etc.).

For Office Use Only

_____

_____

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (specify below)
_____

Ajay Gulati, B.D.S., M.S., P.A. and associates

Informed Consent

CONSENT TO DENTAL PROCEDURES: Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by non surgical root canal therapy or Endodontic surgery where indicated. I understand that all root canal treatment procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result or cure. I also understand that only root canal treatment will be done by the Endodontist and I have to go back to my family dentist for the permanent restoration or crown fabrication. I understand that my existing restorations, bridges or crowns may fracture when gaining access to the root canal.

X RAYS: I consent to any necessary diagnostic procedures and understand that dental radiographs will be made as necessary and appropriate for examinations, diagnosis, consultation, and root canal treatment.

MEDICAL/DENTAL INFORMATION: I consent to allow Dr Gulati and associates to contact any and all entities who may have information essential to my treatment including my physician, pharmacies, and family. I also accept full responsibility for the payment of such services at the time of root canal treatment.

FINANCIAL RESPONSIBILITY: I understand that I will be charged for treatment according to the fee schedule in effect. A fee estimate will be provided prior to beginning treatment and I must be prepared to pay for services as they are performed. The entire payment must then be completed before such treatment is finished. I understand that not all services performed may be covered by my Insurance contract, and fees charged may differ from that determined by my Insurance company. I authorize and assign payment directly to Rockwall-Heath Endodontics. I understand that I am responsible for any balance. I authorize Dr. Ajay Gulati BDS, MS, PA or my insurance company to release any information required to process my claims. Dr. Ajay Gulati's office will only file primary dental insurance. Your walk out statement will provide all information needed to file with your secondary or medical insurance.

CHECK WRITING POLICY: All checks over $500.00 require a major credit card as a second form of payment guarantee. A $25.00 fee will be charged for all returned checks.

CANCELLATION POLICY: There will be a charge of $150.00 if a surgical treatment appointment is cancelled with less than 2 working days notice. All other appointments require 1 full working day's notice for any change or fee of $90.00 will be charged. Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timely manner.

DISCONTINUANCE OF TREATMENT: I understand that the practice reserves the right to discontinue dental treatment whenever it is considered advisable in my best interest and in the interest of the practice.

My signature on this form certifies that I have read and understand the information provided on the form and that I accept dental care and treatment under the described terms and conditions.

Patient Signature: _____Date: _____

If signed by other than the patient, indicate relationship: _____

Doctor Signature: _____

Witness Signature: _____

Ajay Gulati, B.D.S., M.S., P.A. and associates

Consent for Non-Surgical Endodontic Treatment

Patient Name:_____ Birth Date: _____

Root canal therapy is an attempt to save a tooth which otherwise may require extraction. We like our patients to be informed about root canal treatment and its alternatives, and to have their consent before we begin treatment.

Non-Surgical Procedure(s):_____

1. There are certain potential risks inherent in any treatment plan or procedure. I understand the risks include, but are not limited to: complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. The complications includes, but are not limited to: swelling, sensitivity, bleeding, pain, infection, cold sores, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth which is transient but on infrequent occasions may be permanent; reactions to injections, changes in occlusion (biting); jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth, crowns or bridges; referred pain to ear, neck and head; nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure. Fractures of the tooth (teeth) or crown(s) may occur during or after treatment.
2. Specific to non-surgical root canal therapy, risks include, but are not limited to, the possibility of instruments broken within the root canals; perforations (extra opening) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers; loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which make treatment impossible or which may require dental surgery. These complications may include, but are not limited to, blocked canals due to filling or prior treatment, natural calcification, broken instrument, curved roots, periodontal (gum) disease and splits or fractures of the teeth.
3. I do understand that during and following treatment, I may have periods of discomfort. I further understand that many factors contribute to the success or failure of root canal therapy which cannot be determined in advance. Therefore, in some cases treatment may have to be discontinued before it is completed, or may fail following treatment. Some of these factors include, but are not limited to, my resistance to infection, the shape and location of the canal anatomy, my failure to keep scheduled appointment, the failure of my having the tooth restored following the treatment, periodontal (gum) involvement, or an undetected or an after the fact caused split (crack) in the tooth. I further understand that during and following treatment, I am to contact the dentist if I have any additional questions, or experience any unexpected reactions. It will be my responsibility to contact my referring dentist to see if any other treatment needs attention. I hereby give permission for the use of radiographs and/or photographs taken during the course of treatment to be used in lectures, seminars and/or printed in a professional journal for educational purposes. At the end of the endodontic procedure, a recall appointment should be made by the patient within one year to evaluate healing.
4. I further understand that prescribed medications and drugs may cause drowsiness and lack of awareness and coordination, which may be exaggerated by the use of alcohol, tranquilizers, sedatives or other drugs. It is not advisable to operate any vehicle or

hazardous device until recovered from their effects. The use of antibiotic (penicillin, etc.) drugs may have an adverse action on the effect of birth control pills.

5. I have been given the opportunity to have my questions answered in terms I understand concerning the nature of the treatment, the inherent risks of the treatment. I understand that I will always have the option of no treatment or extraction as opposed to acceptance and/or continuance of recommended treatment. I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

My signature on this form certifies that I have read and understand the information provided on the form and that I accept dental care and treatment under the described terms and conditions.

Patient Signature: _____Date: _____
(if minor, signature of a parent or legal guardian)
Relationship to patient: _____

Doctor Signature: _____Date: _____

Witness Signature: _____Date: _____

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WELCOME!

Thank you for your recent call to schedule a new patient appointment. We would like to make your visit to our office as pleasant and relaxing as possible. Together with providing the best possible endodontic treatment, caring for your needs and comfort is our prime concern. We look forward to meeting you and answer any questions you may have regarding your endodontic treatment.

Please find enclosed new patient forms that we would like you to complete. If you have time to get them to us by mail or FAX prior to your appointment, this would be appreciated. It will let the doctor prepare for any special needs that you might require during your initial examination.

Our offices are located:
3018 Ridge Road, Suite 100, Rockwall, Texas 75032.
3101 Joe Ramsey Blvd. E, Suite 103-B, Greenville, TX. 75401.
The directions to our office are enclosed.

Should you have any questions prior to your appointment date, please do not hesitate to call us. Once again, we look forward to meeting you.

Sincerely,

Ajay Gulati, B.D.S., M.S., P.A.
ROCKWALL-HEATH ENDODONTICS
ENDODONTIC ASSOCIATES OF EAST TEXAS (Greenville)

ROCKWALL-HEATH ENDODONTICS
3018 RIDGE ROAD, SUITE 100
ROCKWALL
TEXAS. 75032

Coming from the east (heading west on I-30):

- *Take exit 67 to Ridge Rd. (FM 740)*
- *Turn left at Ridge Road (under I-30)*
- *We are located on Ridge Road opposite Kroger, Dickey's BBQ*

Coming from the west (heading east of I-30):

- *Exit 67A toward Village Dr/Horizon Rd (after crossing over the lake)*
- *Turn right onto Horizon Road*
- *Turn right on Ridge Road which is at the 1st stop light.We are located on Ridge Road opposite Kroger, Dickey's BBQ*

ENDODONTIC ASSOCIATES OF EAST TEXAS
3101 JOE RAMSEY BLVD E, SUITE 103 B
GREENVILLE
TEXAS. 75032

COMING FROM THE WEST

- *I-30 EAST*
- *Take exit 94-A/Denison (US 380)/McKinney onto US-69 N*
- *Turn left onto Joe Ramsey Blvd East (US-69 N)*
- *Pass Wesley Street (US-34)*
- *First left onto Mazeland Business Center*
- *Endodontic Associates of East Texas is Suite 103-B*

COMING FROM THE EAST

- *I-30 WEST*
- *Take exit 94-A/Denison (US 380)/McKinney onto US-69 N*
- *Turn right onto Joe Ramsey Blvd East (US-69N)*
- *Pass Wesley Street (US-34)*
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