Emergency & Family Dental Care

Welcome to UrgentDent P.C., where we are here for all of your dental needs. Don't let our name fool you! We are an emergency AND regular family dental practice. Feel free to speak to our patient coordinators to set up an appointment to see any of our Doctors for an examination and any of our Dental Hygienists for a cleaning!

With locations in Munster and Merrillville, Indiana, and regular office hours Monday through Saturday from 9:00 am to 7:00 pm, we are here to better serve you!

We have a great NEW service for you! **"Patient Connect 365"**

Go to www.patientconnect365.com & sign up for.....

- Get email and/or text appointment reminders
- Request appointments online
- Be alerted when you're due for your next checkup
- Access your appointment and treatment history online
- Receive special discounts and promotions from our office
- Pay your bills online

Don't forget to [Like] our Facebook pages

- Urgent Dent (Merrillville)
- Urgentdent PC (Munster)

The greatest compliment we can receive is when you tell your family and friends about the service you received. We appreciate you choosing us! It would be greatly appreciated if you share and rate your experience on our Google or our Facebook pages!

Thank you,
UrgentDent, P.C.
Dr. Ajmal Wardak & Associates

9352 Calumet Ave. • Munster, IN 46321
Phone 219-513-0555 • Fax 219-513-0666

757 E. 81st Place • Merrillville, IN 46410
Phone 219-513-0777• Fax 219-472-0017

Open Monday - Saturday 9 a.m. - 7 p.m.

PATIENT REGISTRATION

How did you hear about our practice?

☐Family/Friend ☐Phone Book ☐Billboard ☐Online/Website ☐Social Media ☐Other ____________________
☐Referred by Doctor: ________________________________

Do you have a regular family dentist? ☐Yes ☐No Dentists Name: ________________________________

Notifications: *We would like to send you Email and/or Text appointment reminders.*

Below, please provide the contact information that you would like for us to use:

☐Email address: ____________________________________
☐Cell Phone: _________________________

Patient Information:

Patient is: ☐Policy Holder/Guarantor ☐Child of Guarantor ☐Spouse of Guarantor ☐Other _______________

First Name ____________________________ Last Name _____________________________ Middle Initial ________

Preferred Name _________________ Date of Birth _________________ Social Security # _________________________

Address _____________________________ Apt # ______ City ________________ State ______ Zip Code ___________

Home Phone ______________________ Work Phone _______________________ Cell Phone ______________________

Sex: ☐Male ☐Female Marital Status: ☐Divorced ☐Married ☐Separated ☐Single ☐Widowed

Driver License # _____________________ State ______ Email Address: _____________________________________

Guarantor Information: ☐Self (*If you ARE the Guarantor you do NOT need to fill out the following information*)

Guarantor is: ☐Parent of Patient ☐Spouse of Patient ☐Other _______________

First Name ____________________________ Last Name _____________________________ Middle Initial ________

Preferred Name _________________ Date of Birth _________________ Social Security # _________________________

Address _____________________________ Apt # ______ City ________________ State ______ Zip Code ___________

Home Phone ______________________ Work Phone _______________________ Cell Phone ______________________

Sex: ☐Male ☐Female Driver License # ________________________ State ______

URGENTDENT, P.C. MERRILLVILLE

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______________________

Do you have, or have you had, any of the following?

Condition	Yes	No
AIDS/HIV Positive	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No
Anemia	◯ Yes	◯ No
Angina	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No
Asthma	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No
Breathing Problem	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No
Cancer	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No
Cold Sores/Fever Blisters	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No
Convulsions	◯ Yes	◯ No
Cortisone Medicine	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Drug Addiction	◯ Yes	◯ No
Easily Winded	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No
Epilepsy or Seizures	◯ Yes	◯ No
Excessive Bleeding	◯ Yes	◯ No
Excessive Thirst	◯ Yes	◯ No
Fainting Spells/Dizziness	◯ Yes	◯ No
Frequent Cough	◯ Yes	◯ No
Frequent Diarrhea	◯ Yes	◯ No
Frequent Headaches	◯ Yes	◯ No
Genital Herpes	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No
Hay Fever	◯ Yes	◯ No
Heart Attack/Failure	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No
Heart Pacemaker	◯ Yes	◯ No
Heart Trouble/Disease	◯ Yes	◯ No
Hemophilia	◯ Yes	◯ No
Hepatitis A	◯ Yes	◯ No
Hepatitis B or C	◯ Yes	◯ No
Herpes	◯ Yes	◯ No
High Blood Pressure	◯ Yes	◯ No
High Cholesterol	◯ Yes	◯ No
Hives or Rash	◯ Yes	◯ No
Hypoglycemia	◯ Yes	◯ No
Irregular Heartbeat	◯ Yes	◯ No
Kidney Problems	◯ Yes	◯ No
Leukemia	◯ Yes	◯ No
Liver Disease	◯ Yes	◯ No
Low Blood Pressure	◯ Yes	◯ No
Lung Disease	◯ Yes	◯ No
Mitral Valve Prolapse	◯ Yes	◯ No
Osteoporosis	◯ Yes	◯ No
Pain in Jaw Joints	◯ Yes	◯ No
Parathyroid Disease	◯ Yes	◯ No
Psychiatric Care	◯ Yes	◯ No
Radiation Treatments	◯ Yes	◯ No
Recent Weight Loss	◯ Yes	◯ No
Renal Dialysis	◯ Yes	◯ No
Rheumatic Fever	◯ Yes	◯ No
Rheumatism	◯ Yes	◯ No
Scarlet Fever	◯ Yes	◯ No
Shingles	◯ Yes	◯ No
Sickle Cell Disease	◯ Yes	◯ No
Sinus Trouble	◯ Yes	◯ No
Spina Bifida	◯ Yes	◯ No
Stomach/Intestinal Disease	◯ Yes	◯ No
Stroke	◯ Yes	◯ No
Swelling of Limbs	◯ Yes	◯ No
Thyroid Disease	◯ Yes	◯ No
Tonsillitis	◯ Yes	◯ No
Tuberculosis	◯ Yes	◯ No
Tumors or Growths	◯ Yes	◯ No
Ulcers	◯ Yes	◯ No
Venereal Disease	◯ Yes	◯ No
Yellow Jaundice	◯ Yes	◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________________

Comments: ______________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ______________

UrgentDent

Emergency & Family Dental Care

GUARANTEE OF PAYMENT

****

Name: ____

Address: ____

____

Phone Number: _________________________

Date of birth: ______________________

SSN: ___________________________

Employer Name: _______________________________________

Insurance Company: ___________________________________

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All of our licensed dentists are independent contractors through UrgentDent P.C.

For: Professional services rendered or to be rendered to guarantor or family members.

Guarantor agrees to be responsible to UrgentDent P.C. for payment of services rendered or to be rendered to guarantor and family members.

All collection cost, including attorney's fees will be the guarantor's responsibility in the event that judicial action become necessary. Failure on the part of UrgentDent P.C. to pursue legal action upon default shall not be deemed a waiver of any rights hereinabove described.

______________________ ____

Date Signature of Guarantor

____

Printed name of Guarantor

____

Patients name (If different from Guarantor)

UrgentDent
Emergency & Family Dental Care

CANCELLATION & NO-SHOW POLICY

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We at UrgentDent, understand that there are instances when appointment need to be cancelled or reschedules. However, time with the *Dentist or Hygienist* has been set aside specifically for you.

We simply ask that you notify our office as soon as possible. You must cancel your appointment 24 hours in advance to not be charged.

The cancellation / no-show fee is ***$35.00.*** You will be billed personally, as insurances do not cover fees for missed appointments.

I have read and understand the policy and how it applies to me.

Patient Name: ______________________________________

Patient Signature: ___________________________________

Date: ______________________

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ACKNOWLEDGEMENT OF HIPAA POLICY

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Please ask receptionist if you would like a copy of the HIPPA Policy.

I, ______________________________________ have reviewed a copy of UrgentDent's HIPAA health information privacy and security policies and procedures.

Print Name: ___________________________________

Signature: _____________________________________

Please list any person(s) we may contact, if any:

____

____

Date: ______________________