Welcome to our office

Here are some important office policies we would like to share with you...

1. Notice of broken appointment fee:
   There will be a required 48-hour notice of cancellation for appointments scheduled. If a 48-hour notice is not received, there will be a **$75. 00** per hour charge.

2. Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits, however we can only provide you with an estimate. We care for patients from many different insurance companies. Each company is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles, procedures that are down graded and required co-payments.

3. Our courtesy service to you includes:
   - Filing your insurance within 48 hours of your visit and requesting payment on your behalf to our office.
   - Researching your dental insurance plan to advise you of benefits available to you.
   - Following the American Dental Association guidelines for coding procedures and filing insurance.

4. Our expectations of you as the owner of the policy:
   - Payment of fees not covered by your insurance plan at the time the service is rendered.
   - Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
   - Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance and not on our fees or recommended treatment.
   - Taking responsibility for payment if the insurance company does not pay our office within 90 days.
   - Keeping our office informed of any changes in your insurance coverage or employment.

I hereby authorize Dr. Praveena Petluri to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Praveena Petluri, DMD, PLLC. I understand I am responsible for any unpaid balance.

_____ _____

Signature of Patient/Insured Date

Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

I,_____, have

received a copy of this office's Notice of Privacy Practices.

Print Name_____

Signature_____

Date_____

For Office Use Only

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

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify)

_____

_____

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_____

Welcome

We are pleased to welcome you to our practice. Please take a few moments to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date_____ Home Phone (___)_____ Cell Phone (___)_____

Name_____ Social Security #_____

Last Name First Name Middle Initial

Address_____ E-mail_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthday_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School_____ Occupation _____

Employer/School Address_____ Employer/School Phone (___)_____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (___)_____

Primary Insurance

Main Subscriber of Insurance _____

Last Name First Name Middle Initial

Relation to Patient_____ Birthdate_____ Social Security #_____

Address (if different from patients) _____ Phone (____)_____

City_____ State_____ Zip_____

Employed by _____ Occupation _____

Business Address_____ Business Phone (___)_____

Insurance Company _____

Member ID # _____ Group # _____

Name of other dependents covered under this plan _____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to **Praveena Petluri, DMD.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

Dental History

Reason for Todays Visit_____ Date of last dental care_____

Former Dentist_____ Date of last dental X-rays_____

Address_____

Check ( ) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in mouth

How often do you floss?_____ How often do you brush?_____

Medical History

Physicians Name_____ Date of Last Visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐Yes ☐No

Have you had any serious illnesses or operations? ☐Yes ☐No If yes, describe_____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates_____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Check ( ) if you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

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_____

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_____

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_____

ALLERGIES

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