Sunshine Creative Smiles

Anala Panchumarti, D.M.D.

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PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Middle Initial

Address _____ Driver's License # _____

City _____ State _____ Zip _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Email Address: _____

Sex ❑ M ❑ F Age _____ D.O.B. _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ D.O.B. _____ Soc. Sec # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

Date of Last Dental Care _____

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

❑ Bleeding gums ❑ Grinding teeth, clenching ❑ Clicking or popping jaw ❑ Sores or growths in your mouth
❑ Worn out teeth ❑ Loose teeth or broken fillings ❑ Bad breath ❑ Abnormal bleeding after dental appt
❑ Dry mouth ❑ Sensitive teeth ❑ Tobacco use ❑ Chemical drug abuse
❑ Sensitive teeth (to hot/cold) ❑ Bulimia / Anorexia ❑ Acid reflux ❑ Previous orthodontic treatment

Is there anything about the appearance of your teeth that you are unhappy with or would like to improve?
(Examples: size, shape, color, spaces, etc.) ❑ Yes ❑ No If yes, explain: _____

_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, please describe _____

Have you had a history of radiation or chemotherapy? ❑ Yes ❑ No _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate dates _____

Are you taking any blood thinners? (Aspirin, Plavix, Coumadin) ❑ Yes ❑ No _____

(Women) Are you pregnant? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No _____

Are you taking any Bisphosphonates? (Actone, Fosamax) ❑ Yes ❑ No _____

Have you taken Aredia or Zomet ❑ Yes ❑ No _____

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

❑ AIDS / HIV ❑ Anaemia ❑ Anaphylaxis ❑ Anxiety/Nervous Problems ❑ Artificial Joints
❑ Artificial Heart Valves/Pacemaker ❑ Asthma ❑ Back Problems ❑ Cancer ❑ Diabetes
❑ Epilepsy/Seizures ❑ Excessive Bleeding ❑ Fainting ❑ Glaucoma ❑ Headaches/Migraine
❑ Heart Murmur ❑ Heart Problems-Describe ❑ Hemophilia/Bleeding Disorders ❑ Hepatitis ❑ Herpes
❑ High Blood Pressure ❑ Jaundice ❑ Kidney Problems ❑ Liver Problems ❑ Mitral Valve Prolapse
❑ Psychiatric Disorders ❑ Persistent Cough ❑ Scarlet Fever ❑ Shortness of Breath ❑ Stroke
❑ Thyroid Problems ❑ Tuberculosis ❑ Sickle Cell Disease ❑ Rheumatic Fever, Rheumatism
❑ Congenital Heart Disease / Heart Murmurs ❑ Respiratory Disease - COPD, Emphysema

MEDICATIONS

List any medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin ❑ Latex ❑ Penicillin
❑ Barbiturates (Sleeping Pills) ❑ Sulfa
❑ Codeine ❑ Metal Allergies ❑ Other _____
❑ Local Anesthetic _____
❑ None

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date: _____

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Please Print Name: _____

Dental Insurance Payment Agreement

Our office is pleased to enable you to utilize your dental insurance to help pay for your dental treatment. Our staff is highly trained in the complexities of dental insurance to provide prompt, efficient service. Unfortunately your policy can be difficult and confusing. Our policy regarding your coverage is as follows:

- Rarely does dental insurance cover all dental expense.
- **Most plans have deductibles and co-insurance payments, which MUST be met by you at the time of service.**
- The portion of the bill covered by insurance is only an estimate. Your insurance does not guarantee payment to us.
- The insurance policy is an agreement between you and your insurance carrier.
- Any remaining balance after payment from your insurance is **YOUR RESPONSIBILITY. PAYMENT ON REMAINING BALANCES IS DUE IMMEDIATELY UPON RECEIPT OF FINAL STATEMENT.**

Appointment Policy Agreement

Dr. Anala reserves adequate time for her patients so they can receive the best care possible.

If you are unable to keep your appointment kindly give our office 48 hours notice, in order to help serve other patients who may need that appointment time. **FAILURE TO GIVE 24 HOUR NOTICE will result in a fee applied to your account. ($35.00 for hygiene and $50 for Dr. Anala).** This fee will need to be paid in full before any future appointments can be made.

All payments are due at the time of services.

Thank you for your continued patronage.

I have read and understand the above agreement and terms. I fully accept responsibility for my insurance coverage and agree to pay any remaining balances in addition I understand the office policy in reference to appointments.

_____ _____

Signature **Date**