Welcome to the office of Dr. Padma Daggula

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____ I prefer to be called: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Widow ☐ Divorced ☐ Separated

Social Security # _____ Birth Date: _____

Address: _____ _____
Street **Apartment #**

_____ _____ _____
City **State** **Zip Code**

Phone Hm: _____ Cell: _____ Wk: _____

Email: _____ May we call you at work? ☐ Yes ☐ No

What is the best way to contact you? ☐ Home ☐ Work ☐ Cell ☐ Email

Would you like to receive appointment reminders via: EMAIL ☐ Yes ☐ No TEXT MESSAGE ☐ Yes ☐ No

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment – relationship to patient _____

Name: _____ ☐ Male ☐ Female
Last First MI

Social Security # _____ Birth Date: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone Hm: _____ Cell: _____ Wk: _____

Email: _____ May we call you at work? ☐ Yes ☐ No

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment Occupation: _____

Employer/Company Name: _____ Phone: _____

Address: _____
Street City State Zip Code

Insurance payments must be received within 60 days of the date of service, after 60 days patient is responsible for payment.

Insurance Information

Primary

Name of Insured: _____ Birth Date: _____
Last First MI

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent or Guardian ☐ Other _____

Social Security # _____ ID #: _____ Group # _____

Insurance Plan Name: _____ Phone: _____

Address: _____
Street City State Zip Code

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Do you have dual coverage? ☐ Yes ☐ No If yes, please provide additional coverage info. on the reverse side so we can assist you in filing for reimbursement. **Sorry, we do not accept assignment of benefits on secondary insurance. ➡➡**

Additional Insurance Information

Secondary

Name of Insured: _____ Birth Date: _____
Last First MI

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent or Guardian ☐ Other _____

Social Security # _____ ID #: _____ Group # _____

Insurance Plan Name:_____ Phone: _____

Address: _____
Street City State Zip Code

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ Sign ☐ Internet ☐ Other Dental Office ☐ Yellow Pages ☐ Work ☐ Another patient, friend ☐ Another patient, relative ☐ Other _____

Name of person referring you to our practice: _____

Financial Agreement & Consent for Services

The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. As a condition of treatment by this office the patient/ responsible party understands that all dental services performed are charged directly to the patient and payment in full will be due at the time treatment is performed, unless financial arrangements have been made in advance.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that this office cannot render services on the assumption that our charges will be paid by an insurance company and that he or she is personally responsible for payment of all dental services. Our office will help prepare the patients insurance forms to assist in making collections from insurance companies, and when arrangements are made in advance our office will credit such collections to the patient's account. However, patient understands that any unpaid insurance balance after 60 days and any balance not satisfied by insurance regardless of the basis for nonpayment are the responsibility of the patient, due in full upon receipt of billing statement.

A monthly service charge of $25 on unpaid balances may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services to be rendered to me by the office of Dr. Daniel C. Bush, I grant my permission to you or your assignee to telephone me to discuss matters related to this form, finances, and/or treatment. I agree to pay therefore the reasonable value of said services to Dr. Bush, or his assignee, at the time services are rendered or according to the financial arrangements made. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

My signature below represents that I have read the above and agree to the entire content, and authorize Dr. Bush and/or his dental staff to perform dental services I may need during diagnosis and treatment.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Thank you for choosing our office to meet your dental health needs. Please provide us with medical and dental history information by answering the questions below and on the reverse side of this form. ➡

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS or HIV Positive
- ☐ Allergic Reactions
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Valves
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ **Codeine Allergy**
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fever Blisters/Herpes
- ☐ Frequent Snoring
- ☐ Glaucoma
- ☐ Growths/Tumors
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ Immune Deficiency
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ **Latex Allergy**
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Major Hospitalizations
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Penicillin Allergy**
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexual Trans Disease
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Condition
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:

- ☐ _____
- ☐ _____

ALLERGIES:

- ☐ _____
- ☐ _____

Your current physical health is ☐ Good ☐ Fair ☐ Poor

- Do you now or have you ever taken **Bisphosphonates** (bone density enhancement) Ex: Fosamax, Actonel, Boniva?

  ☐ Yes ☐ No If yes, please list drug Name:_____Dosage:_____How long?_____

- Are you currently taking any medication **(including over-the-counter drugs/vitamins)**? ☐ Yes ☐ No

  If yes, please list: _____

_____

- Have you had any reaction to medications, such as codeine, etc.? ☐ Yes ☐ No

  If yes, please list: _____

- Do you have a personal physician? ☐ Yes ☐ No Date of last physical exam: _____

  Name of Physician: _____ Phone:_____

- Are you currently under the care of a physician? ☐ Yes ☐ No

  If yes, please explain:_____

Name of Physician: _____Phone:_____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain:_____

- Do you smoke or use smokeless tobacco? ☐ Yes ☐ No If yes, how much? _____

  Would you like information to help you quit? ☐ Yes ☐ No

- Do you consume alcoholic beverages? ☐ Yes ☐ No
- Are you currently using any illegal drugs? ☐ Yes ☐ No

For Women

- Are you taking birth control pills? ☐ Yes ☐ No
- Are you pregnant? ☐ Yes ☐ No If yes, due date _____
- Are you nursing? ☐ Yes ☐ No

Please provide Dental information on reverse side. ➡ ➡

Dental Information

Date of Last Dental Visit: _____ **Reason for this visit:** _____

- Why have you come to the dentist today? _____

_____

- Are you currently in pain or do you have any dental problems? ☐ Yes ☐ No
  If yes, please explain: _____
- Are any of your teeth sensitive to cold, heat, or anything else? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had complications / difficult problem associated with previous dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- **Do you need to be pre-medicated w/antibiotics prior to having dental treatment?** ☐ Yes ☐ No
  If yes, with what medication: _____
- Do you floss your teeth daily? ☐ Yes ☐ No
- Do your gums bleed easily when brushing or flossing? ☐ Yes ☐ No
- Do your gums feel swollen or painful? ☐ Yes ☐ No
- Have you been told or do you feel you have gum (periodontal) problems? ☐ Yes ☐ No
- Do you feel it is important to keep your natural teeth? ☐ Yes ☐ No
- Do you have problems chewing or swallowing your food? ☐ Yes ☐ No
- Do you have pain, discomfort, or clicking in your jaw joint when chewing? ☐ Yes ☐ No
- Do you wake up in the morning with a headache? ☐ Yes ☐ No
- Do you often have headaches and/or tired chewing muscles? ☐ Yes ☐ No
- Do you grind your teeth? ☐ Yes ☐ No
- Have you ever had orthodontics? ☐ Yes ☐ No
- Have you ever had oral surgery? ☐ Yes ☐ No
- Are you wearing removable dental appliances? ☐ Yes ☐ No
- Do you snore? ☐ Yes ☐ No
- Are you nervous about dental treatment? ☐ Yes ☐ No
- What can we do to make you most comfortable? _____

_____

- Are you unhappy with the appearance of your smile ☐ Yes ☐ No Rate your smile: (yuk!) 1 2 3 4 5 (smiles!)
  If yes, please explain: _____

_____

- Do you have any other condition or disease you think the doctor should know about? ☐ Yes ☐ No
  If yes, please explain: _____
- Is there anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

To the best of my knowledge all of the information I have given is true and correct. If I ever have any changes in my health I will inform the doctor at the next appointment without fail.

_____ **Date**: _____

Signature of patient, parent or guardian