



Vani M. Patibandla, DDS New Patient Information

Welcome to our practice! Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

Patient _____
SS # _____
Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Sex M F Married Widowed Single Minor
 Separated Divorced Partnered for _____ Years
E-mail _____ Cell Phone _____ Cell Phone #2 _____
Employer/School _____ Employer/School Phone _____
Employer/School Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to Patient _____
Address _____ Home Phone _____
Drivers License # _____ Birthdate _____ Bank _____
Employer _____ Work Phone _____
Currently a patient in our office? Yes No Email _____ Cell Phone _____

INSURANCE INFORMATION

Name of insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max Annual Benefit _____

ADDITIONAL INSURANCE

Name of insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____



Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

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 the teeth
- Sensitivity to cold
- Sores or growth in your mouth

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

MEDICAL HISTORY

Physician's 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 illness or operations? Yes No If yes, describe _____

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

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check if you have had any of the following:

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

Current medications and correlating diagnosis:

Allergies:

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and / or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Vani Patibandla 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 above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when the treatment plan is completed or one year from the date signed below.

Signature of patient, parent, guardian _____ Date _____

Printed name of patient, parent _____ Relationship _____