Patibandla Dental

We'll keep you smiling!

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_____
SSN_____
Date_____

Patient Information

Name_____Birthdate_____Home Phone_____
Address_____City_____State_____Zip Code_____
Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

Email_____Cell Phone_____Cell Phone #2_____
Employer/School_____Employer/School Phone_____
Employer/School Address_____City_____State_____Zip Code_____

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 persona
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 Code_____
Insurance Company_____Group #_____Union or Local #_____
Address_____City_____State_____Zip Code_____
How much is your deductible?_____How much have you used?_____Annual Max._____

Additional Insurance

Name of Insured_____Relationship to Patient_____
Birthdate_____Social Security #_____Date Employed_____

Employer_____Work Phone_____
Employer Address_____City_____State_____Zip Code_____
Insurance Company_____Group #_____Union or Local #_____
Address_____City_____State_____Zip Code_____
How much is your deductible?_____How much have you used?_____ Annual Max._____

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
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths 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 illnesses or operations? Yes____No____ If yes, describe_____
Have you ever had a blood a blood transfusion? Yes_____No_____ If yes, when?_____
Women: Are you pregnant? Yes_____ No_____ Nursing? Yes_____ No____ Taking birth control? Yes___No___

Check if you have had any of the following:

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

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 send when the treatment plan is completed or one year from the date signed below.

Signature of patient, parent, or guardian_____Date_____
Printed name of patient, parent or guardian_____Relationship_____