Ph # 214-872-2700 / 2705
Fax # 214-872-2701

Dr. Vijaya TippiReddy, DDS -- *12388 FM 423, Suite # 100, Frisco, Texas 75033*

PATIENT REGISTRATION AND MEDICAL HISTORY

Patient: _____ Today's Date: _____
Last **First** **Middle Initial**

Home Address: _____City_____

State/Zip:_____Email:_____

Sex: □M □F Date of Birth: _____Age: _____ SS#: _____

Check one: □ Single □ Married □ Divorced □ Widowed Name of Spouse: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Your Occupation: _____ Employer: _____

Employer address:_____

Parent or Guardian of Minor: _____SS# of Parent: _____

Person Responsible for Payment of Account: _____

Whom may we thank for referring you? _____

EMERGENCY INFORMATION: Name: _____ Relationship: _____

(*Someone NOT living with you*) Address: _____ Phone #: _____

Dental Insurance Information (*Policyholder Information* ***DO NOT FILL IF CARD PRESENT***):

Subscriber Name: _____ SS#:_____

Date of Birth: _____ Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Phone #: _____ Group #: _____

This information is strictly confidential and WILL NOT be released to anyone without your consent. It is important, for your safety that the Doctor knows about your Medical and Dental history. Please make sure this form is accurately completed to the best of your knowledge.

Patient Signature: (or parent if minor) _____Date: _____

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General Medical History:

Do you currently have health problems? Yes/No If yes, please explain_____

_____ _____

Are you under the care of a Physician? Yes/No if yes, please explain _____

_____ _____Date of last exam:_____

Have you been hospitalized within the last 5 years? Yes/No If yes, please explain _____

_____

Physician's Name: _____Phone #: _____

Women Only:

Are you pregnant? ..... Yes/No

If yes, what is the estimated due date?_____

Are you nursing? ..... Yes/No

Do you take oral contraceptives? ..... Yes/No

Please list all medications that you are taking, including non-prescription drugs:

Have you ever had an allergic or adverse reaction to any of the following? If so, please circle:

Local Anesthetics	Penicillin	Ibuprofen	Jewelry/Metals
Topical Anesthetics	Erythromycin	Codeine	Aspirin
Nitrous Oxide	Sulfa Drugs	Latex	Lidocaine/Marcaine
Iodine	Other: _____		

Patient Signature: (or parent if minor) _____Date: _____

Doctor Signature: _____ Date: _____

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Do you currently or have you ever had any of the following conditions? Please circle as it applies:

Heart Trouble	Hepatitis A (infection)	Asthma
Heart Attack	Hepatitis B (serum)	Emphysema
Open-Heart Surgery	Hepatitis C	Autoimmune Disease
Tuberculosis (TB)	Liver Disease	Multiple Sclerosis
Heart Pacemaker	Kidney Disease	Shortness of Breath
Artificial Heart Valve	Bleeding Disorder	Sinus Trouble
Mitral Valve Prolapse	Anemia	Head/Neck Injury
Congenital Heart Defect	HIV	Gout
Heart Disease	Jaundice	Mental Disorders
Heart Murmur	Respiratory Problems	Stomach Problems
Rheumatic Fever	AIDS	Arthritis
Rheumatic Heart Failure	Drug Addiction	Seasonal Allergies
Angina (chest pain)	Alcoholism	Steroid Therapy
Congestive Heart Failure	Diabetes	Glaucoma
Swollen Ankles	Ulcers	Tumors/Growths
High Blood Pressure	Fainting Spells	Cancers
Low Blood Pressure	Epilepsy/Seizures	Chemo/Radiation
Artificial Joint/Implant	Stroke	Organ Transplant
Thyroid Problem	Sexually Transmitted Disease	Marked Weight Change
Nervous Disorders		

Other Medical Problems: _____

Patient Dental History

Yes/No Do your gums bleed while brushing or flossing?
Yes/No Are your teeth sensitive to hot/cold liquids/foods?
Yes/No Are your teeth sensitive to sweet or sour liquids/foods?
Yes/No Do you feel pain in any of your teeth?
Yes/No Do you have any sores or lumps in or near your mouth?
Yes/No Have you ever had any head, neck, or jaw injuries?
Yes/No Clicking in the jaw?
Yes/No Do you have any other condition, disease, or problem not contained herein that should be brought to the dentist's attention? Please explain: _____
_____
_____

Yes/no Do you have frequent headaches?
Yes/No Do you clench or grind your teeth?
Yes/No Do you bite your lips or cheeks frequently?
Yes/No Have you ever had any previous difficulty with extractions?
Yes/No Have you ever had prolonged bleeding following extractions?
Yes/No Have you ever had any orthodontic treatment?
Yes/No Do you wear complete/partial dentures? Yes date made: _____
Yes/No Have you ever received oral hygiene instructions regarding your teeth and gums?
Yes/No **Do you like your smile? If no explain:** _____
_____

Patient Signature: (or parent if minor) _____**Date**: _____

Doctor Signature: _____**Date**: _____

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At V Smile Family Dental, we want to take optimum care of our patients. We might require more information than other dental offices, but it is to assist you in having a full and healthy life.

If you have any of the following conditions, V Smile Family Dental requires documentation from your physician stating if you need prophylactic antibiotics prior to any dental treatment.

- Heart Murmur
- Mitral Valve Prolapse
- Joint Replacement
- Screws, pins or plates placed in bones
- Heart valve replacement (mechanical or porcine)
- Stent
- Cardiac Pacemaker
- Shunt
- Organ Transplant

If you are taking the following medications, V Smile Family Dental requires documentation from your physician stating if you need to stop your medications prior to any dental treatment.

- Warfarin
- Coumadin
- Plavix
- Clopidogrel
- Skelid
- Didronel
- Actonel
- Fosamax
- Boniva
- Zometa
- Aredia

You may either bring the medical release from your physician at your appointment or have physician's office fax the medical release to 972-377-4780. Please make sure the medical release has your full name and date of birth referenced.

I understand that if I have any of the above conditions or take any of the above medications:
I am responsible for providing V Smile Family Dental with the appropriate documentations from my physician before my appointment or my appointment will be rescheduled. I understand that withholding information about my health condition could be harmful to me.

_____ _____

Patient's Signature **Date**

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V SMILE FAMILY DENTAL
COMPASSION . EXCELLENCE . BEAUTY

At **V Smile Family Dental**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initial

_____ ■ Your dental benefits are based upon a contract made between **your employer** and the **insurance company**. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

_____ ■ We currently accept all private care insurance plans. This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ***ONLY AN ESTIMATE***. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

_____ ■ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, V Smile Family Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and YOUR INSURANCE COMPANY. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ ■ V Smile Family Dental does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history, a **$25.00** fee will be charged for all returned checks). If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, 12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_____ ■ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 48 hour** notice to avoid a $**40/hour cancellation fee** (emergencies are an exception).

I agree with the above conditions.

Print Name: _____ **Date**: _____

Patient/Parent Signature: _____

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Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act OF 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Discuss financial and accounting information to all patients on your financial account
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information have informed me. I have been given a copy of your *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization to obtain a current copy of the *Notice of Privacy Practices*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____**Signature**:_____

Relationship to patient: _____**Date**: _____