Durga Devarakonda, DMD PLLC
Family and General Dentistry

DD Family Dentistry
972-245-3395

PATIENT INFORMATION

PLEASE COMPLETE THE FOLLOWING FORMS TO YOUR FULLEST KNOWLEDGE. DOING SO HELPS US BETTER CARE FOR YOU!

Today's Date: _______ /_______ /________ REASON FOR INITIAL VISIT: ______________________________________

Whom may we thank for referring you? ____

FIRST ________________________ MI_____ LAST__________________________ PREFERRED______________________

ADDRESS: ____
Street City/State Zip

HOME PHONE: _____________________________________ WORK PHONE: ______________________________________

CELL PHONE: _______________________________ EMAIL: ____

DATE OF BIRTH: ________ / ________ / _________ AGE: ______ GENDER: M / F

SS#: ____ DRIVERS LICENSE #: ____________________________

Marital Status: MARRIED / DIVORCED / SEPARATED / WIDOWED / SINGLE

SPOUSE or GUARDIAN: ____ DOB: _____/ ______/ ______

SPOUSES SS#: ____________________________ PHONE#: ____
PLEASE PROVIDE BEST # TO BE REACHED AT

PERSON RESPONSIBLE FOR ACCOUNT, INCLUDING ALL BALANCES NOT COVERED BY INSURANCE

____

INSURANCE INFORMATION: PLEASE PROVIDE ALL INFORMATION BELOW; BY NOT DOING SO YOU MAY HAVE TO PAY IN FULL FOR TREATMENT TODAY AND BE REIMBURSED BY YOUR INSURANCE COMPANY. THANK YOU.

GUARANTOR OF ACCOUNT (IF OTHER THAN PATIENT): ____

GUARANTOR'S SS#: ___________________________________ GUARANTOR'S DOB: ___________________________

Insurance ID: ___________________________________ GUARANTOR'S EMPLOYER: _____________________________

Some insurance companies use social security numbers only. Please provide both if an ID is on your insurance card.

GUARANTOR'S ADDRESS: ____

INSURANCE COMPANY: ____ PHONE#: _______________________________

CLAIMS ADDRESS: ____
P.O. BOX CITY/STATE ZIP

GROUP #: ____________________ GROUP NAME: ____

Please provide your driver's license and insurance card. Both are required for proof of identity and insurance coverage.

Physician Information: ____ (____) __________ -______________

Durga Devarakonda, DMD PLLC **DD Family Dentistry**
Family and General Dentistry **972-245-3395**

The disclosure of medical information is for your general welfare as well as ours, whether you are here for a consultation or a major dental procedure. Your general health may have a significant effect on your current dental condition and on the outcome of any proposed treatment. For the good of your overall health and safety please answer all questions as thoroughly as possible.

Are you currently under the care of a physician for any reason? YES / NO

Please explain: ______________________________

When was your last physical exam? ____________ Was anything abnormal? YES / NO

Please explain: ______________________________

When was your last visit to a dentist? __________ What for? ______________

Have you ever had any operations, hospitalizations or major illnesses? YES / NO

Please explain: ______________________________

Do you smoke or chew tobacco? …………………………………………………… YES / NO

Are you currently or have you ever taken Phen-Phen or similar medication? ………………… YES / NO

Is there a past history of alcohol, chemical dependency, psychiatric treatment, nervous, emotional or eating disorder that may affect the care we provide you? YES / NO

PLEASE EXPLAIN: ______________________________

Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? Y / N

Have you ever been instructed to take antibiotics before receiving dental treatment? YES / NO

FEMALES:
Are you or could you be pregnant? ……………………………YES / NO
Are you taking birth control? ……………………………………YES / NO
Are you nursing? ………………………………………………YES / NO

FYI:
ANTIBIOTICS COULD INTERFERE WITH THE EFFECTIVEMESS OF ORAL CONTRACEPTIVES

Do you have any other diseases or health concerns not listed? YES/ NO

Please explain: ______________________________

PREFERRED PHARMACY NAME AND LOCATION: ______________________________

PHONE#: ______________________________

I CERTIFY THAT THE MEDICAL HISTORY I HAVE GIVEN ABOVE IS CORRECT.

______________________________ ______________
PATIENT OR GUARDIAN SIGNATURE DATE

______________________________ ______________
DR. SIGNATURE DATE

GENERAL HEALTH QUESTIONNAIRE

PATIENT NAME: **DATE OF BIRTH:** / /

DO YOU HAVE OR EVER HAD:

	YES	NO			YES	NO
Rheumatic Fever				Asthma		
Congenital Heart Disease				Emphysema		
Mitral Valve Prolapse				Sleep Apnea		
Heart Valve Replacement				Tuberculosis		
Prosthetic (artificial joints)				Chronic Sinus Problems		
Angina (chest pain)				Thyroid Problems		
Cardiac Pacemaker				Glaucoma		
High/Low Blood Pressure (Circle)				Kidney Disease		
Stroke/TIA				Liver Disease/Hep A, B, C		
Bleeding Problems				Diabetes		
Anemia				Ulcers or Colitis		
Seizures/Epilepsy				Arthritis/ Joint/ Back pain		
Dizziness/Fainting				Radiation/ Chemotherapy		
Sexually Transmitted Disease				TMJ symptoms/treatment		
HIV/AIDS				Osteoporosis		

Please list additional health concerns:

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

	YES	NO			YES	NO
LOCAL ANESTHETICS				SEDATIVES, BARBITURATES		
PENICILLIN/AMOXICILLIN				CODEINE		
SULFA DRUGS				OTHER NARCOTICS		
OTHER ANTIBIOTICS				ASPIRIN OR IBUPROFEN		
IODINE/BETADINE/NEOSPORIN				LATEX OR ADHESIVE TAPE		

PLEASE LIST ADDITIONAL ALLERGIES:

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS:

	YES	NO			YES	NO
ANY TYPE OF BLOOD THINNER				DIURETICS/WATER PILLS		
ASPIRIN OR IBUPROFEN				INSULIN		
COUMADIN				BLOOD PRESSURE MEDS		
VITAMIN E				PREDNISONE/STEROIDS		
GLUCOSAMINE				OSTEOPOROSIS MEDICATION		

PLEASE LIST ALL CURRENT MEDICATIONS:

.Durga Devarakonda, DMD PLLC

DD Family Dentistry

4221 Medical PKWY ST# 200

Carrollton, TX 75010

Consent for Treatment

1. I, ______________________________________, hereby authorize Dr. Durga and designated staff to take x-rays, study models and photographs and employ any other diagnostic tools deemed appropriate to make a thorough diagnosis of my or my dependent's dental needs.

2. Upon diagnosis, I authorize Dr. Durga and staff to perform all recommended treatment that has been mutually agreed upon and to employ assistance as required to provide proper care.

3. I agree to the use of anesthetics and other medication as necessary. I fully understand that the use of anesthetic agents carries inherent risks and that at any time I may request a recitation of possible complications.

4. I do/do not (circle one) consent to appointment reminders and messages via text and/or e-mail. Initial: ______________

5. I am comfortable with Dr. Durga and staff discussing my dental concerns with the following family and/or friends (list name and relationship to patient):
   a. ____
   b. ____
   c. ____

Signature: ____

Printed Patient/Guardian Name: __________________________________

Date: ______________ Guardian Relationship: _____________________

Durga Devarkonda, DMD 4221 Medical PKWY, Ste 200 Carrollton, TX 75010 972-245-3395

Financial Responsibility

Thank you for choosing us as your dental care provider. We sincerely desire to treat our patients in a pleasing, congenial atmosphere and find this can best be accomplished when a clear understanding exists regarding financial arrangements. The following information provides the basis for the financial aspect of your treatment. Please contact the office at any time with questions regarding your financial responsibility.

PAYMENT: Fees for services are due when treatment is rendered. For those with insurance your co-pay and deductible will be due at time of service. Payment may be made by cash, check or credit card. Our office also offers financing through CareCredit®. In the case of minors and dependents, the accompanying adult is responsible for all copays the day services are rendered. We will provide receipts so that financial disputes between parents/guardians may be resolved with the help of a third party, without the inclusion of our office.

INSURANCE: If you have dental insurance, we will make a good faith estimate of your benefits (your estimated co-pay is due the day services are rendered) and defer billing you for that amount, if not paid by insurance, for up to 30 days. We will file the appropriate claim information forms with your insurance company, provided you supply us with documented evidence of coverage. If your insurance provider denies coverage, or if we otherwise do not receive payment, the amount will then become due and payable by you no matter what the reason for non-payment. Unless notified of changes to your insurance policy a $5 fee will be assessed if we must refile your claim.

RETURNED CHECKS: A *$35.00 processing fee* will be charged for each returned check.

BILLING CHARGES: Any account remaining unpaid 90 days from date of service may be assessed a billing charge of *$10 each month* the balance is not paid in full. After 6 months we may impose a fee of to 5% of the total balance per month at our discretion.

NON-PAYMENT: In the event the charges incurred are not paid in full when due and collection action is instituted, the patient is responsible for additional cost associated with such collect activity. The collection costs may include and are NOT limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law. This could also include a finance charge and billing fee each month after the allowed 30 days.

CANCELLATION: Any reminders (phone call, text, e-mail or postcard) are a courtesy and are not guaranteed. Patients needing to cancel appointments must speak to someone in the office a minimum of 2 business days prior to the scheduled appointment. Cancellations may not be left on the voicemail. Failure to properly notify the office may result in a charge of up to $45.00 per hour of scheduled time.

I HAVE READ THE FINANCIAL RESPONSIBILITY FOR DENTAL SERVICES AND AGREE TO THE TERMS AND ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES FOR SERVICES RENDERED. I UNDERSTAND ALL POLICIES ARE SUBJECT TO CHANGE WITHOUT NOTICE.

____________________________________ ____________________

Patient or Guardian Signature Date

____

Relationship to Patient (If Other Than Self)

Durga Devarakonda, DMD PLLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

NAME: ____ DATE OF BIRTH: ______________

ADDRESS: ____

TELEPHONE: __________________________ EMAIL: __________________________________

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY!

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment and healthcare operations. Such uses include filing insurance, communicating with other doctors and sending prescriptions to pharmacies on your behalf. Failure to sign this consent will preclude us from performing these tasks.

Note of Privacy Practices: You have the right to read our Notice of Privacy Practices (NPP) before signing this consent. Our NPP provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our NPP is available for you to read upon request.

We reserve the right to change our privacy practices described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice by contacting:

Durga Devarakonda
Phone: (972)245-3395 Fax: (972)245-3953
4221 Medical PKWY STE 200
Carrollton, TX 75007

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE:

I, ________________________________, have had full opportunity to request the NPP and consider the contents of this consent form. I understand that by signing this consent form, I am giving my full consent to your use and disclosure of my protected health information to carry out your treatment, payment and healthcare operations.

Signature: ______________________________ **Date:** ______________

(If this is signed by a personal representative or parent, complete the following)

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________