12850 10th Street
Suite B2
Chino CA 91710
(909)627-6699
lovemydentist@gmail.com

Smile Artistry, Vijaya Cherukuri D.D.S.

www.smileartistrychino.com

Welcome to our Practice

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

In the case of an emergency who should be notified? Please enter name, relationship, and phone number below:

* _____

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Responsible Party Information:

This ONLY needs to be filled out if the insurance subscriber is other than patient, or if patient is UNDER 18.

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Insurance Company, Phone Number and Insurance Subscriber ID:

_____

Insurance Authorization:

* ☐ I authorize the use of this electronic signature on all insurance submissions, my insurance company to pay the dentist all insurance benefits rendered, and the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Please provide the name and phone number of your medical physician. Include your medical/record number if you have it, and the date of your most recent physical exam.

*

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

*

Please list any know specific allergic reactions:

*

Do you take or require antibiotic premedication for your dental visits?

* ◯ Yes ◯ No

Are you currently on any blood thinners?

* ◯ Yes ◯ No

History of Bone Density Treatment (including use of bisphosphonate)?

* ◯ Yes ◯ No

Dental Information

Previous Dentist's name, phone number and how long were you a patient there.

*

Date of most recent dental exam and dental x-rays:

*

What is your immediate concern?

*

How fearful of dental treatment are you on a scale of 0 (least) to 10 (most)?

*

Additional comments or questions:

Medical History

Indicate which of the following conditions you have or have had.
Checking a box will indicate a "YES", leaving blank will indicate a "NO".

Allergies	Anemia	Arthritis
Artificial Joints	Asthma	BISPHOSPHONATE'S
Blood Disease	Blood Thinners	Cancer
Codeine Allergy	Diabetes	Dizziness
Epilepsy	Excessive Bleeding	Fainting
Glaucoma	Growths	Hay Fever
Head Injuries	Heart Disease	Heart Murmur
Hepatitis	High Blood Pressure	HIV
HIV	Jaundice	Kidney Disease
Latex Allergy	Liver Disease	Mental Disorders
Mitral Valve Pro	Nervous Disorders	Other
Pacemaker	Penicillin Allergy	Pregnancy
PRE-MED PATIENT	Radiation Treatment	Respiratory Problems
Rheumatic Fever	Rheumatism	Sinus Problems
Stomach Problems	Stroke	Thyroid Disease
Tuberculosis	Tumors	Ulcers

☐ Venereal Disease

* ☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

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Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients with dental insurance understand that all dental servies are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) daysof billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Consent for Internet Communications

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please

understand that we have, and always will respect the privacy of your health information. We may need to use your personal information to remind you of your appointments. I understand that all email communications in which I engage may be forwarded to other providers for the purposes of providing treatment to me. This may include but not be limited to sending you x-rays and/or minimal personal information to other providers via email. We strive to keep all patient information secure but unfortunately there is no assurance of confidentiality of information when communicating this way.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

Signature: _____ Date: _____

Cancellation/No Show Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have a Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

We ask that you give our office 48 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred with out the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged. After three consecutive no shows or cancellations, appointments will be scheduled on a walk in basis.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the cancellation policy and agree to its terms.

Signature: _____ Date: _____

Response Date: 6/23/2017