Thank you for choosing us as your dental healthcare team! We promise to always provide you with the best possible dental care for you and your family. In order to meet your dental healthcare needs, please fill out this form completely. If you have any questions, please ask us – we're happy to help!

Patient Information

Today's Date _____

Name _____ Date of Birth _____ Sex _____

Address _____ City, State, Zip _____

How long at this address? _____

Main Phone _____ Work Phone _____ Cell Phone _____

E-mail _____

How did you hear about us? _____

Emergency Contact _____ Phone _____ Relation _____

Responsible Party Information

Name _____ Social Security # _____

Address _____ City, State, Zip _____

E-mail _____ Preferred Phone _____ Work Phone _____

Occupation _____ Employer _____

Dental Insurance Information

Insurance Company _____ Insured Name _____

Insured DOB _____ Relationship to Patient _____

Subscriber # _____ Group # _____ Employer _____

Secondary Dental Insurance Information

Insurance Company _____ Insured Name _____

Insured DOB _____ Relationship to Patient _____

Subscriber # _____ Group # _____ Employer _____

Insurance Co. Address _____ Phone _____

Dental History

Name of Last Dentist _____ Last Visit? _____

Reason for today's visit? _____

Have you ever had a serious problem from a previous dental treatment? **Yes** ☐ **No** ☐

If yes, please explain: _____

How often do you: Brush _____ Floss _____ Get cleanings _____

Please mark the ones that apply to you:

- ☐ Hesitant to come to the dentist
- ☐ Gums bleed during brushing and flossing
- ☐ Have a bad odor or taste in mouth
- ☐ Food frequently gets stuck in teeth
- ☐ Have fillings you don't like
- ☐ Snore or have trouble sleeping
- ☐ Would like whiter teeth
- ☐ Would like straighter teeth
- ☐ Have missing teeth you would like replaced
- ☐ Have loose dentures or partials

Is there anything you don't like about your smile? _____

Authorization and Release

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Notice of Electronic Communication: Due to the changing world of healthcare and technology, we now have the ability to provide our patients with certain types of information via e-mail and/or text messaging.
We believe strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from us via email or text messaging. We do not share the names, e-mail addresses, and/or telephone numbers of patients with any other companies, or with any other patient.
By placing my name and date below, I acknowledge that I have read and understand the above statement on emails and text messages. Should I have any questions, I can contact the practice at any time. I hereby give permission to send messages to me via email and/or text messaging as means of communication.

Patient/Guardian Signature _____ Date _____

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations

Patient/Guardian Signature _____ Date _____

Photograph, Slide, and Video Consent: I hereby authorize Dr. Bindya Reddy to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, and professional publications. I further understand that if the photographs, slides, and/or videos are used in any publication, or as part of a demonstration, all reasonable attempts will be made to conceal my identity.

Patient/Guardian Signature _____ Date _____