KISHORE THAMMINENI DDS
1330 AMHERST ST, # B
WINCHESTER, VA 22601

Name_____Middle_____Last_____

Street_____City_____State_____Zip_____

Cell Phone_____Home Phone_____Work Phone_____

Email Address_____Preference for Contact: Cell ( ) Home ( ) Email ( )

Patient Social Security_____ Patient Date of Birth_____Sex ( ) Male ( )Female

Drivers License _____ Emergency Contact_____

Relationship to Patient _____ Contact Phone Number_____

How did you hear about us? Please circle one: Phone Book Internet Newspaper Flyer Billboard Radio Other_____

Primary Insurance Information **PLEASE PRESENT INSURANCE ID CARD TO FRONT DESK**

Subscriber Name_____ Subscriber Social Security_____

Date of Birth_____ Relationship to Patient: Please circle one Self Spouse Child Other

Employer Name: _____ Employer Phone_____

Insurance Company_____Group#_____

Insurance Phone_____

Secondary Insurance Information **PLEASE PRESENT INSURANCE ID CARD TO FRONT DESK**

Subscriber Name_____ Subscriber Social Security_____

Date of Birth_____ Relationship to Patient: Please circle one Self Spouse Child Other

Employer Name: _____ Employer Phone_____

Insurance Company_____Group#_____

Insurance Phone_____

HEALTH INFORMATION – CONFIDENTIAL

Last Physical Date: _____ Physicians Name and Phone: _____

Reason for today's visit: _____

Work related injury? (circle) **YES NO** Have you been or are you currently under the care of a physician? (circle) **YES NO**

Date of last dental visit: _____ Have you ever been hospitalized? (circle) **YES NO**

Date of last dental x-rays: _____ Have you ever had Novocain / other local anesthetic? (circle) **YES NO**

Are you interested in tooth whitening? (circle) **YES NO**

If wearing dentures; age of current dentures? _____ Are you interested in new dentures? (circle) **YES NO**

Are you currently taking or have you taken any steroid/cortisone therapy in the past 2 years? (circle) **YES NO**

Are you currently taking or have you taken any oral bisphosphonates, e.g. FOSAMAX, ACTONEL, BONIVA, or IV bisphosphonates, e.g. ZOMETA, AREDIA? (circle) **YES NO** How long did you take them? _____

Have you ever been required to take antibiotics prior to having a dental treatment, i.e. pre-medicate? (circle) **YES NO**

Any adverse reactions or sickness related to: (circle) penicillin, aspirin, codeine, local anesthetics, latex, metals, other medications?

List any medications you are allergic to:

_____

List any medications you are taking, including non-prescription drugs and vitamins/herbal remedies

_____

Do you have any history of:

Rheumatic Fever	Y N	Thyroid Disease	Y N	Cancer (Type:_____)	Y N
Mitral Valve Prolapse	Y N	Blood Transfusion	Y N	Heart Murmur	Y N
Heart Trouble (_____)	Y N	Pace Maker/Open Heart Surgery	Y N	High Blood Pressure	Y N
Low Blood Pressure	Y N	H.I.V. Positive/AIDS	Y N	Liver Disease	Y N
Use of Tobacco Products	Y N	Psychiatric Treatment	Y N	Pain in Jaw Joint (TMJ)	Y N
Artificial Knee, Hip, Other Joint	Y N	Hepatitis (Type:_____)	Y N	Latex Allergy	Y N
Chemotherapy	Y N	Allergies or Hives	Y N	Excessive Bleeding	Y N
Lung Disease	Y N	Tuberculosis	Y N	Asthma	Y N
Epilepsy or Seizures	Y N	Fainting or Dizziness	Y N	Drug Addiction	Y N
Mouth Sores/Growths	Y N	Any Type of Implant	Y N	Ulcers or Stomach Problems	Y N
Sinus Problems	Y N	Radiation Treatment	Y N	Aspirin/Anticoagulant Therapy	Y N
Dialysis	Y N	Kidney Disease	Y N	Arthritis	Y N
Venereal Disease	Y N	Stroke	Y N	Anemia	Y N
Diabetes	Y N	Alcoholism	Y N	Teeth grinding/Clenching	Y N
Any Type of Transplant	Y N	Other_____			

Is there anything you wish to speak with the doctor privately about? (circle) **YES NO**

Women:

Is there a possibility of pregnancy? **YES NO** Are you currently nursing? **YES NO** Are you currently taking birth control pills? **YES NO**

If pregnant, Expected delivery date? _____ Obstetrician/Gynecologist _____

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your regular physician/gynecologist for assistance regarding additional methods of birth control.

Patient Section

I certify that I have read and understand the questions above and have answered them to the best of my knowledge. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of the staff responsible for any errors that I have made in the completion of this form.

(REQUIRED)

Patient or Guardian Signature _____ Date_____ Reviewing Dentist _____ Date _____

Patient or Guardian Signature _____ Date_____ Reviewing Dentist _____ Date _____

TREATMENT PLAN RELEASE

I authorize Winchester Dental Care to perform the necessary treatment plan.

Patient or Guardian Signature_____ Date_____

PAYMENT AGREEMENT

I understand and agree that health, dental and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I understand and agree that this office, as a courtesy to me, will not impose any interest charges to any balance I may incur for period of thirty days after the charges are incurred, to afford my insurance carrier, if any, that amount of time to make payment. It is understood that any balance outstanding for more than thirty days will be charged interest at the rate of 1.5 percent per month and I agree to pay said charges. In the event my account balance is referred to an agency or attorney for collections purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court cost.

In the event that the patient is a minor, I am the parent and/or said guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature_____Date_____

(if patient is a minor, Parent or Guardian must sign)

AUTHORIZATION OF PAYMENTS OF BENEFITS

I hereby authorize payment directly to Winchester Dental Care. I agree that a photocopy of this authorization is as valid as the original.

Patient or Guardian Signature_____Date_____

NOTICE OF PRIVACY PRACTICES

HIPAA REQUIREMENTS

Winchester Dental Care (the Practice)

a. Is required by federal law to maintain your privacy of PHI (Protected Health Information) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
b. Under the Privacy Rule, The Practice may require by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI that that which is provided for under Federal Law.
c. Is required to abide by the terms of this Privacy Notice.
d. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice effective for your entire PHI that it maintains.
e. Will distribute any revised Privacy Notice to you prior to implementation.
f. Will not retaliate you for filing a complaint.

Effective Date:

This notice is in effect as of 6/10/2016

Patient Acknowledgement:

By subscribing my name below, I acknowledge receipt of a copy of this Notice and my understanding and my agreement to its terms.

Patient Signature_____Date_____

APPOINTMENT CANCELLATION POLICY

We require 24 hours' notice for cancellations. If we do not receive proper notice, there will be a $30.00 no show fee.

Signature_____Date_____

CREDIT CARD AUTHORIZATION

By signing hereunder, I hereby authorize Winchester Dental Care to bill my charge card account should any balance for services remain outstanding for more than sixty (60) days. If the account information given expires or is otherwise discontinued, I agree to give Winchester Dental Care information as to an alternate charge account which may be used. My account is as follows:

( ) VISA ( ) MASTERCARD ( ) DISCOVER ( ) OTHER_____

Account number_____

Expiration Date_____

Signature_____ Date_____