Prabhavathi Prattipati DMD, MS
311 8th Ave, SW Childersburg, AL 35044
Phone: 256-378-5442● FAX: 256-378-5427●info@primesmiledental.com

New Patient Information Form

Patient Information

Full Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (Home) _____ (Cell) _____

Email: _____

Preferred method of contact: ☐ Phone ☐ Email ☐ Text

Emergency Contact

Name: _____Relationship to Patient: _____

Phone: _____

Insurance Information

Dental Insurance Company: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Social Security Number: _____

Policy ID/Member #: _____Group #: _____

Employer: _____

Medical History Form

Patient Name: _____Date of Birth: _____
Primary Care Physician: _____Physician Phone: _____
Pharmacy Name & Phone: _____

General Health

Are you currently under a physician's care? ☐ Yes ☐ No If yes, explain: _____

Have you been hospitalized or had any surgeries in the past 5 years? ☐ Yes ☐ No If yes, explain: _____

Have you ever had any serious illness or injury? ☐ Yes ☐ No If yes, explain: _____

Do you require antibiotics before dental procedures? ☐ Yes ☐ No

Are you pregnant or nursing? ☐ Yes ☐ No If yes, how many weeks? _____

Do you smoke or use tobacco products? ☐ Yes ☐ No

Medications and Allergies

Are you currently taking any prescription, over-the-counter medications, supplements, or herbal remedies? ☐ Yes ☐ No
Please list all medications:

Do you have any of the following allergies? (Check all that apply)
☐ Penicillin ☐ Latex ☐ Aspirin ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Codeine or other narcotics ☐ Metals ☐ Other: _____

Medical Conditions (Check all that apply)

Cardiovascular

☐ High Blood Pressure
☐ Heart Attack
☐ Angina/Chest Pain
☐ Irregular Heartbeat
☐ Pacemaker
☐ Heart Murmur
☐ Rheumatic Fever
☐ Congenital Heart Disease
☐ Mitral Valve Prolapse
☐ Stroke

Endocrine

☐ Diabetes (Type I / Type II)
☐ Thyroid Problems

Bleeding Disorders

☐ Anemia
☐ Easy Bruising
☐ Excessive Bleeding

Neurological

☐ Seizures/Epilepsy
☐ Fainting Spells
☐ Alzheimer's / Dementia
☐ Depression / Anxiety

Bone/Joint

☐ Arthritis
☐ Joint Replacement
☐ Osteoporosis
☐ Bisphosphonate Use

Respiratory

☐ Asthma
☐ Emphysema/COPD
☐ Sleep Apnea
☐ Snoring/Nasal Obstruction
☐ Tuberculosis (TB)
☐ Shortness of Breath

Infectious Diseases

☐ HIV/AIDS
☐ Cold Sores/Herpes
☐ Hepatitis A / B / C

Other Conditions

☐ Cancer (Type: _____)
Radiation/Chemo Date: _____
☐ Gastrointestinal Disorders
☐ Kidney or Liver Disease
☐ Autoimmune Disease (e.g., Lupus,)

Signature: _____ Date: _____

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HIPAA Privacy Acknowledgment

I acknowledge that I have received and/or reviewed the Dental Office's **Notice of Privacy Practices** regarding how my medical information may be used and disclosed.

Patient Name: _____

Signature: _____ **Date:** _____

☐ I authorize messages regarding appointments or care to be left at:
☐ Home ☐ Cell ☐ Work ☐ With another person (Name): _____

Financial Policy

Thank you for choosing our office for your dental care. We are committed to providing excellent care and making financial arrangements as simple as possible.

Please review and initial each section:

_____ I understand that I am financially responsible for all charges for services rendered, regardless of insurance coverage.

_____ Payment is due at the time services are rendered. We accept cash, checks, major credit cards, and CareCredit.

_____ For patients with dental insurance, we will submit your claims as a courtesy. However, any remaining balance is your responsibility.

_____ Returned checks will incur a $35 fee.

Signature: _____ **Date:** _____

24-Hour Cancellation Policy

To ensure that we can provide timely care to all of our patients, we request that you notify us at least **24 hours in advance** if you need to cancel or reschedule an appointment.

- Missed appointments or cancellations with less than 24 hours' notice will incur a **$25 fee per hour**.

We appreciate your cooperation and understanding.

Patient Signature: _____ **Date:** _____