

What to expect at your first visit

Dr. Sowmya Punaji strives to make Legacy Dental Care visit the most comfortable experience you have had in a dental practice. One of the cornerstone of this comfort experience is providing a thorough and comprehensive initial consultation.

Since all patients and their dental needs are unique, we start with this comprehensive approach with all patients so we can formulate a tailored plan for you together with you. The typical initial visit consists of the following:

- Completion of new patient forms
- Review of primary dental concerns and past dental history
- Review of past medical history as certain health conditions have significant bearing on your dental care
- Digital X Rays of teeth obtained [as X Rays outside of six months are too old for treatment planning]
- Tooth by tooth examination with a small tooth brush sized video camera
- Oral cancer screening examination
- Periodontal examination for gum disease
- Discussion of dental needs and wants to create a directed plan to improve your dental health and smile
- The visit commonly takes 90 minutes

Many patients desire a dental cleaning at the time of their initial visit.

We try to provide this service whenever possible, however, some factors such as medical history or the nature of the cleaning that is required can prevent routine cleaning from being scheduled for the First visit.



Dr. Sowmya Punaji DDS

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Personal Information

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called _____ Male Female

Address _____ City _____ State _____ ZIP _____

Date of Birth _____ Social Security # _____

Cell Phone _____ Work Phone _____ Home Phone _____

Primary contact number (please check one) Cell Work Home

Email _____ Employer _____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you? _____

Are you currently a student ? School _____ Grade/Year _____

Emergency contact person/ contact number _____

Dental Information

Reason for today's visit _____

Are you currently in pain? Yes No

If so, please describe _____

Do you have any dental problems right now? Yes No

If so, please describe _____

Have you ever had trouble with previous dental treatment? Yes No

If so, please describe _____

Anything we can do to improve upon your past dental treatments? _____

Please rate your level of anxiety about seeing the dentist (least) 1 2 3 4 5 (most)

Have you used nitrous oxide (laughing gas) for past treatment? Yes No

If not, would you be interested in trying nitrous oxide when having dental treatment completed ? Yes No



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Approximate Date of last cleaning _____

Procedure(s) done at last dental visit _____

Are you looking for a change in the way your smile looks? Yes No

If you could change anything about your teeth, it would be (check all that apply)

- Color of your teeth
- Size/Shape of your teeth
- Gaps between your teeth
- Other _____
- Too much or too little of teeth show when you smile
- Too much or too little gum shows when you smile
- Alignment of your teeth

Do you have? (check all that apply)

- Sensitive or receding gums
- Missing teeth
- Teeth sensitive to heat/cold
- Concerns about bad breath
- Other _____
- Worn/broken/chipped teeth
- Old crowns that have dark edges at the top
- Teeth sensitive while chewing
- Old or discolored fillings

Have you ever experienced ? (check all that apply)

- | | | | |
|-----------------------------------|--|---------------------------------------|--|
| Periodontal disease/gum treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Discomfort in you jaw point (TMJ/TMD) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Orthodontics treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Your bite adjusted or balanced | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Oral surgery/ Wisdom Teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Serious injury to the mouth or head | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| A bite plate or mouth guard | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic bad breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Snoring | <input type="checkbox"/> Yes <input type="checkbox"/> No | Grinding of teeth (day or night) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes to any of the previous questions, please describe _____

Do you require antibiotics before dental treatment? Yes No If yes, why? _____

Have you ever taken, currently take, or plan to take medication for osteoporosis? (Bisphosphonates) Yes No

Is there anything else about your past dental treatment(s) that you would like us to know? _____



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Dental Insurance

Primary Carrier:

Insurance co. name _____ Insured's I.D. no. _____
Insured's name _____ Relationship to patient _____
Date of birth of Insured _____ Insured's employer name _____

Secondary Carrier:

Insurance co. name _____ Insured's I.D. no. _____
Insured's name _____ Relationship to patient _____
Insured's date of birth _____ Insured's employer name _____

If the patient is a minor:

Name of parent or legal guardian and relationship _____

Is this parent or legal guardian currently a patient in our office? [] Yes [] No

Office and Financial Policy

Our mission is to deliver the finest, most cost-effective health care treatment available today. Following diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the investment in today's and future treatment.

Payment is due at the time services are rendered. For your convenience we accept cash, personal check, Visa, MasterCard, Discover and American Express. We also offer convenient payment options through CareCredit.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies may not pay for all your costs. Your insurance policy is a contract between you and your insurer. As a courtesy we will be glad to file your claim for you provided we have complete and accurate insurance information. You will be expected to pay for services rendered if the office is unable to verify your insurance information prior to treatment. If payment for services already rendered has not been paid within 60 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible. Your cooperation with this policy will assure equitable treatment of insured and non-insured patients.

We reserve the right to charge and collect fees for broken appointments. Appointments are reserved exclusively for you. We consider an appointment confirmed once the appointment is scheduled. A minimum charge of \$80 may be posted to your account if an appointment is cancelled without a 48 hour advance notice. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

A returned check fee of \$35 will be added to your account balance for any checks returned to us as non-sufficient funds (NSF). Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment.

I, the undersigned, authorize payment of the dental benefits otherwise payable to me, directly to Legacy Dental Care. I have read and understand this financial policy.

DATE

PRINT NAME

SIGNATURE



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Photography Release

I _____, hereby authorize Dr. Sowmya Punaji 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, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature

Date

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but, acknowledgement could not be obtained because:

- Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgment
Other (Please Specify)

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you _____

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problem <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____