Anna Smiles
DENTAL CENTER
Pavani Inapuri, DMD

817 W White St, Suite 100, Anna, TX, 75409
Ph: (214) 631-9199 Fax: (877) 209-0956
info@annasmilesdental.com

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Middle Initial

Address _____ Driver's License # _____

City _____ State _____ Zip _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Email Address: _____

Sex ❑ M ❑ F Age _____ D.O.B. _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ D.O.B. _____ Soc. Sec # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

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DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

Date of Last Dental Care _____

Check (✓) if you have had any problems with the following:

❑ Bleeding gums ❑ Grinding teeth, clenching ❑ Clicking or popping jaw ❑ Sores or growths in your mouth
❑ Worn out teeth ❑ Loose teeth or broken fillings ❑ Bad breath ❑ Abnormal bleeding after dental appt
❑ Dry mouth ❑ Sensitive teeth ❑ Tobacco use ❑ Chemical drug abuse
❑ Sensitive teeth (to hot/cold) ❑ Bulimia / Anorexia ❑ Acid reflux ❑ Previous orthodontic treatment

Is there anything about the appearance of your teeth that you are unhappy with or would like to improve?
(Examples: size, shape, color, spaces, etc.) ❑ Yes ❑ No If yes, explain: _____

_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, please describe _____

Have you had a history of radiation or chemotherapy? ❑ Yes ❑ No _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate dates _____

Are you taking any blood thinners? (Aspirin, Plavix, Coumadin) ❑ Yes ❑ No _____

(Women) Are you pregnant? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No _____

Are you taking any Bisphosphonates? (Actone, Fosamax) ❑ Yes ❑ No _____

Have you taken Aredia or Zomet ❑ Yes ❑ No _____

Check (✓) if you have had any of the following:

❑ AIDS / HIV	❑ Anaemia	❑ Anaphylaxis	❑ Anxiety/Nervous Problems	❑ Artificial Joints
❑ Artificial Heart Valves/Pacemaker	❑ Asthma	❑ Back Problems	❑ Cancer	❑ Diabetes
❑ Epilepsy/Seizures	❑ Excessive Bleeding	❑ Fainting	❑ Glaucoma	❑ Headaches/Migraine
❑ Heart Murmur	❑ Heart Problems-Describe	❑ Hemophilia/Bleeding Disorders	❑ Hepatitis	❑ Herpes
❑ High Blood Pressure	❑ Jaundice	❑ Kidney Problems	❑ Liver Problems	❑ Mitral Valve Prolapse
❑ Psychiatric Disorders	❑ Persistent Cough	❑ Scarlet Fever	❑ Shortness of Breath	❑ Stroke
❑ Thyroid Problems	❑ Tuberculosis	❑ Sickle Cell Disease	❑ Rheumatic Fever, Rheumatism	
❑ Congenital Heart Disease / Heart Murmurs		❑ Respiratory Disease - COPD, Emphysema		

MEDICATIONS

List any medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin ❑ Latex ❑ Penicillin
❑ Barbiturates (Sleeping Pills) ❑ Sulfa
❑ Codeine ❑ Metal Allergies ❑ Other _____
❑ Local Anesthetic _____
❑ None

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date: _____