Maneesha Chigurupati DDS

117 KERNEYWOOD STREET
LAKELAND, FL 33803
PHONE: (863)687-2759

DATE: _____

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ PREFERRED NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # ____ - ____ - ____ ☐ MALE ☐ FEMALE

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PREFERRED PHONE #: _____ RECEIVE CORRESPONDENCE VIA ☐ TEXT ☐ EMAIL

E-MAIL ADDRESS: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ RELATION: _____

EMERGENCY PHONE #: _____

PREFERRED PHARMACY

PHARMACY NAME: _____ PHONE #: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

IS SUBSCRIBER THE SAME AS PATIENT? YES ☐ NO ☐

SUBSCRIBER INFORMATION

FIRST NAME: _____

LAST NAME: _____

DATE OF BIRTH: _____

INSURANCE COMPANY

NAME: _____

SUBSCRIBER ID: _____

GROUP #: _____

PATIENT RELATIONSHIP TO SUBSCRIBER

☐ SPOUSE ☐ CHILD ☐ OTHER: _____

SECONDARY DENTAL INSURANCE (IF APPLICABLE)

IS SUBSCRIBER THE SAME AS PATIENT? YES ☐ NO ☐

SUBSCRIBER INFORMATION

FIRST NAME: _____

LAST NAME: _____

DATE OF BIRTH: _____

INSURANCE COMPANY

NAME: _____

SUBSCRIBER ID: _____

GROUP #: _____

PATIENT RELATIONSHIP TO SUBSCRIBER

☐ SPOUSE ☐ CHILD ☐ OTHER: _____

RESPONSIBLE PARTY (other than the patient)

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # ____ - ____ - ____ ☐ MALE ☐ FEMALE

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

RESPONSIBLE PARTY SIGNATURE: _____ DATE ____ / ____ / ____

Date: _____

HEALTH HISTORY

REASON FOR VISIT: ☐ BROKEN TOOTH ☐ CHECK-UP ☐ COSMETIC ☐ DENTURES ☐ TOOTH PAIN

☐ OTHER: _____

ARE YOU UNDER THE CARE OF A PRIMARY CARE PHYSICIAN? ☐ YES ☐ NO DATE OF LAST PHYSICAL: _____

PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE #: _____

ARE YOU TAKING OR HAVE YOU TAKEN ANY STEROID/CORTISONE THERAPY IN THE LAST 2 YEARS? ☐ YES ☐ NO

ARE YOU TAKING OR HAVE YOU TAKEN ORAL BISPHOSPHONATES (E.G., FOSAMAX, BONIVA) OR IV BISPHOSPHONATES, (E.G., ZOMETA, AREDIA)? ☐ YES ☐ NO HOW LONG? _____

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL PROCEDURES? ☐ YES ☐ NO

ARE YOU ALLERGIC OR HAVE YOU HAD AN ADVERSE REACTION TO ANY OF THE FOLLOWING?

☐ NONE ☐ AMOXICILLIN ☐ ASPIRIN ☐ CODEINE ☐ EPINEPHRINE ☐ LATEX ☐ METALS ☐ ANESTHESIA ☐ SULFA

☐ PENICILLIN ☐ SULFA ☐ TETRACYCLINE ☐ OTHER: _____

LIST ANY MEDICATIONS YOU ARE TAKING INCLUDING NON-PRESCRIPTION DRUGS AND HERBALS/VITAMINS:

_____

_____

_____

_____

CHECK ANY CONDITIONS THAT APPLY TO YOU

☐ NONE
☐ ALCOHOLISM
☐ ALLERGIES OR HIVES
☐ ANEMIA
☐ ARTHRITIS
☐ ARTIFICIAL JOIN/PINS
TYPE: _____
AGE: _____
☐ ASPIRIN THERAPY
☐ ASTHMA
☐ BLOOD THINNER
☐ BLOOD TRANSFUSION
☐ BREATHING PROBLEMS
☐ OTHER ILLNESS
TYPE: _____

☐ OSTEOPOROSIS
☐ DEMENTIA
☐ DIABETES
TYPE: _____
☐ DIALYSIS
☐ DRUG ADDICTION
☐ EPILEPSY
☐ EXCESSIVE BLEEDING
☐ FAINTING/DIZZINESS
☐ HEARING IMPAIRMENT
☐ HEART MURMUR
☐ HEART SURGERY
DATE: _____
☐ HEART TROUBLE
TYPE: _____

☐ HEPATITIS
TYPE: _____
☐ HIGH BLOOD PRESSURE
☐ HIV
☐ KIDNEY DISEASE
☐ LIVER DISEASE
☐ LOW BLOOD PRESSURE
☐ LUNG DISEASE/COPD
☐ LUPUS
☐ MITRAL VALVE PROLAPSE
☐ MOBILITY IMPAIRMENT
☐ NON-DENTAL IMPLANTS
TYPE: _____
☐ ORGAN TRANSPLANTS
TYPE: _____
☐ PACE MAKER

☐ PSYCHIATRIC CARE
☐ RADIATION THERAPY
☐ RADIOSURGERY
☐ RHEUMATIC FEVER
☐ SEIZURES
☐ STD
☐ SINUS PROBLEMS
☐ STOMACH PROBLEMS
☐ STROKE
☐ THYROID DISEASE
☐ TUBERCULOSIS (TB)
☐ ULCERS
☐ VISUAL IMPAIRMENT
☐ CANCER
TYPE: _____

DENTAL HISTORY

DATE OF LAST DENTAL VISIT: ☐ I DON'T KNOW EXACT DATE ☐ LAST 6 MONTHS ☐ 6 MONTHS – 1 YEAR ☐ 1 – 3 YEARS ☐ GREATER THAN 4 YEARS ☐ NEVER

DATE OF LAST DENTAL X-RAY: ☐ I DON'T KNOW EXACT DATE ☐ LAST 6 MONTHS ☐ 6 MONTHS – 1 YEAR ☐ 1 – 3 YEARS ☐ GREATER THAN 4 YEARS ☐ NEVER

ORAL HEALTH

HAVE YOU EVER BEEN TREATED FOR PERIODONTAL (GUM) DISEASE? ☐ YES ☐ NO

HAVE YOU EVER HAD NOVOCAINE OR OTHER LOCAL ANESTHETIC? ☐ YES ☐ NO

HOW HAPPY ARE YOU WITH YOUR SMILE (1-10)? _____

ARE YOU CURRENTLY WEARING DENTURES? ☐ YES ☐ NO

AGE OF DENTURES: ☐ LESS THAN 6 MONTHS ☐ 6 MONTHS – 1 YEAR ☐ 1 – 3 YEARS ☐ GREATER THAN 4 YEARS

PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU BELOW

☐ PAIN IN JAW (TMJ) ☐ DIFFICULTY CHEWING/SWALLOWING ☐ USE TOBACCO PRODUCTS ☐ MOUTH SORES

☐ BROKEN/LOOSE TEETH ☐ TEETH GRINDING/CLENCHING ☐ SWOLLEN/BLEEDING GUMS ☐ SENSITIVE TEETH

DO YOU WISH TO SPEAK TO THE DENTIST IN PRIVATE? ☐ YES ☐ NO

WOMEN PATIENTS ONLY

ARE YOU CURRENTLY PREGNANT? ☐ YES ☐ NO ESTIMATED DELIVERY DATE: _____

ARE YOU NURSING? ☐ YES ☐ NO ARE YOU TAKING ANY BIRTH CONTROL PRESCRIPTIONS? ☐ YES ☐ NO

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS AND ACKNOWLEDGE THAT QUESTIONS HAVE BEEN ANSWERED TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE MY CONSENT TO THE DENTIST TO PERFORM AN EXAMINATION AND DIAGNOSE MY CONDITION. I ALSO GIVE MY CONSENT FOR ANY PREVENTATIVE OR BASIC RESTORATIVE PROCEDURES WHICH MAY BE NECESSARY. I UNDERSTAND THAT THIS CONSENT WILL REMAIN IN EFFECT UNTIL TREATMENT IS TERMINATED EITHER BY ME OR THE DENTIST.

PATIENT'S SIGNATURE: _____ DATE ____/____/____