Mamata Ponnaganti, D.M.D.
2235 Nursery Rd.
Clearwater, FL 33764

Demographics

First name:_____

Last name:_____

Sex:_____

Birth date_____/_____/_____

Email address:_____

Phone number:_____

Address line 1:_____

Address line 2:_____

City:_____

State:_____

Postal code:_____

Dental History

Reason for visit_____

Date of last dental visit_____

Date of last dental X-rays_____

How often do you floss_____

How often do you brush_____

Bad Breath_____

Bleeding, Red, Swollen Gums_____

Broken/Loose teeth or fillings_____

Clicking or popping jaw_____

Grinding teeth_____

Pain around ear/side of face_____

Sores/Blisters in mouth_____

List any other dental concerns/pain_____

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Medical History

Allergies

Aspirin	**Yes / No**	Local Anesthetic	**Yes / No**	List of other allergies:
Codeine	**Yes / No**	Penicillin	**Yes / No**	
Latex	**Yes / No**	Sulfa	**Yes / No**	

Cancer	**Yes / No**	Asthma	**Yes / No**	Tumor / growth on head / neck	**Yes / No**
Pacemaker	**Yes / No**	Chemotherapy	**Yes / No**	Artificial Heart Valves	**Yes / No**
Blood Disease	**Yes / No**	Diabetes	**Yes / No**	Congenital Heart Lesions	**Yes / No**
Heart Problems	**Yes / No**	Hepatitis	**Yes / No**	Radiation Treatment (X-Ray/Cobalt)	**Yes / No**
Glaucoma	**Yes / No**	Kidney Disease	**Yes / No**	Artificial Joints / Bones	**Yes / No**
Sinus Trouble	**Yes / No**	Liver Disease	**Yes / No**	Headaches (Frequent)	**Yes / No**
Thyroid Problems	**Yes / No**	Herpes	**Yes / No**	Anemia / Bleeding Problems	**Yes / No**
Stroke	**Yes / No**	AIDS/HIV	**Yes / No**	Emphysema	**Yes / No**
Nervous Problems	**Yes / No**	Epilepsy	**Yes / No**	Shortness of Breath (Breathing Problems)	**Yes / No**
Fainting / Dizziness	**Yes / No**	Tuberculosis	**Yes / No**	Arthritis / Rheumatism / Gout	**Yes / No**
		Ulcer	**Yes / No**	Abnormal (High/Low) Blood Pressure	**Yes / No**

Pregnant	**Yes / No**	Nursing	**Yes / No**

Psychiatric Care_____

List any other medical issues you have_____

List any serious Illnesses / surgeries / hospitalizations_____

List any medications you are taking_____

Signature_____

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Dental Insurance

Name of insured_____

Insured's birth date_____

Insured's address line 1_____

Insured's address line 2_____

Insured's city_____

Insured's state_____

Insured's postal code_____

Patient's relationship to insured_____

Insured's employer name_____

Employer's address line 1_____

Employer's address line 2_____

Employer's city_____

Employer's state_____

Employer's postal code_____

Plan name_____

ID #_____

Group #_____

Insurance company phone number_____

Insurance's address line 1_____

Insurance's address line 2_____

Insurance's city_____

Insurance's state_____

Insurance's postal code_____

COVID-19 PATIENT SCREENING

Do you have a fever or have you felt hot or feverish recently (14-21 days)?

☐ yes ☐ No

Are you having shortness of breath or other difficulties breathing?

☐Yes ☐No

Do you have a cough?

☐ Yes ☐ No

Do you have any flu-like symptoms, such as gastrointestinal upset, headache or fatigue?

☐ Yes ☐ No

Have you experienced recent loss of taste or smell?

☐ Yes ☐ No

Have you had any contact with any confirmed COVID-19 positive patients?

☐ Yes ☐ No

Is your age over 60?

☐ Yes ☐ No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?

☐ Yes ☐ No

Have you traveled in the past 14 days to any regions affected by COVID-19?

☐ Yes ☐ No

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Notice: X-rays and Insurance Coverage

We will recommend that certain x-rays be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.

☐ I understand the above information and agree with its contents. By signing below I agree to be bound by the terms of this agreement

X _____

Notice: Dental Practice Financial Policy

The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following: All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered. All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account. Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

☐ I understand the above information and agree with its contents. By signing below I agree to be bound by the terms and conditions of this agreement

X _____

Rescheduling/No Show Policy

We understand that situations arise in which you must reschedule your appointment. It is therefore requested that if you must reschedule your appointment that you provide more than a 24 hour notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. When rescheduling with less than a 24 hours notice, we are unable to offer that slot to another person.

Office appointments which are rescheduled with less than 24 hours notification may be subjected to a minimum cancellation/rescheduling fee of **$50.00**. Appointments requiring more than an hour of the Doctors time require a 2-3 business day advance rescheduling notice, without notification there may be a minimum cancellation/rescheduling fee of **$150.00**.

Patients who do not show up for their scheduled appointment without a call will be considered a **NO SHOW**. Patients may be subjected to a minimum cancellation/rescheduling fee of **$80.00**. Patients who No-Show two(2) or more times may only be able to make appointments on a day-of-basis in the future.

The fees stated above are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to reschedule appointments within 24 hours. Fees in this instance may be waived, but only with the Doctors approval.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication. Questions about rescheduling and no show fees should be directed to the Billing Coordinator.