

Dattathri B. Malyavantham, D.D.S.

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Ph. (703) 444- 9900
www.ridgetopdental.com

We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: _____

I prefer to be called: _____ Male Female

Birth date: _____ SSN: _____

Home address: _____

Hm # _____ Cell # _____

Wk # _____ Pgr # _____

Email _____

How do you prefer to confirm your appointments?
(H) _____ (W) _____ (C) _____ (E-mail) _____

Employer: _____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us?

Previous / Present Dentist: _____

Date of Last Visit : _____ Ph# _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____

Relation: _____

Wk # _____ Hm # _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Relation: _____

Insured's Birth date: _____

Insured's SSN: _____

Please provide dental insurance card (s).

A note for patients with dental insurance – We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier for free and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. An estimate of your co-payment, deductible and charges not covered will be due at the time of services rendered. If you have any questions regarding your insurance benefits please feel free to ask any one of our staff members for more information. Please familiarize with your specific plan as certain limitations may apply.

Release of Information and Assignment of Benefits:
I hereby authorize **Ridgetop Dental Care** to apply for benefits on my behalf for covered dental services rendered. I request payment to be made to this office directly. *I understand and agree* that regardless of my insurance status, I am ultimately **responsible** for my account and any collection fees that are incurred if the balance is not paid in a timely fashion. I have been informed and agree to the policies of Ridgetop Dental Care as stated above.

Print Name Relationship to Patient

Signature Date

Medical History

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

If yes, please explain: _____

Are you taking any prescription/over the counter drugs? Yes No

If yes, please list: _____

Do you use or smoke tobacco in any form? Yes No

Have you or do you take Redux/Fen Phen or Pondimin? Yes No

For women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No week# _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+/AIDS
Y	N	Arthritis	Y	N	Hospitalized Any Reason
Y	N	Artificial Bones/Joints/Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Latex Allergy
Y	N	Blood Transfusions	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Nervous/Anxious
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any other serious medical condition(s) that you have ever had:

Are you allergic to any of the following items?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other

Please list any other drugs you are allergic to:

Dental History

Why have you come to the dentist today? _____

Many patients consult us for a 2nd opinion. Are you currently seeing another dentist for your dental needs? Yes No

If Yes, please explain: _____

How would you describe the condition of your teeth and gums?
 Good Fair Poor

Are you currently in pain or discomfort with your teeth or gums?
 Yes No If yes, please explain: _____

How often do you brush your teeth? _____ Floss? _____

Do you have sensitive teeth? Yes No

Do your gums bleed when you brush or floss? Yes No

Have you ever experienced pain in you jaw joint? Yes No

Have you ever been treated for TMJ symptoms? Yes No

If yes, please explain: _____

Do you grind or clench your teeth? Yes No

Reason for this visit: _____

Please indicate if you are interested in learning more about the following dental services:

<input type="checkbox"/> Cosmetic Consultation	<input type="checkbox"/> Cosmetic Veneers
<input type="checkbox"/> Tooth Colored Restorations	<input type="checkbox"/> Bonding
<input type="checkbox"/> Cerec “ One Visit ” Crowns	<input type="checkbox"/> Implants
<input type="checkbox"/> ZOOM “ One Visit ” Whitening	<input type="checkbox"/> Teeth Whitening

I understand that this information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. ***I hereby authorize Dr. Datta Malyavantham to take intra-oral photographs and X-rays to aide the diagnosis of my oral health. I understand that the photographs and X-rays will be used as a record of my care and will also be used for patient education.***

Signature _____ Date _____

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Patient HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to Dr. Datta Malyavantham.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature

Date

Witness

Optional: Please **restrict access** to my personal health information (PHI) from:

Name

Address

Phone Number

Optional: Please **allow access** to my personal health information (PHI) to:

Name

Address

Phone Number