

Patient Information

Amberly Family Dentistry Happy Smile.. Healthy Family..

Meena Chelury, DDS, PA

Thank you for visiting Amberly Family Dentistry. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Name:__ LAST FIRST MIDDLE INITIAL NICKNAME Address: STATE CITY STREET ZIP Birth Date: Social Security Number: Female Please Circle: Child Single Married Divorced Widowed Gender: (Please Circle) Male Phone: Home_______ Work_____ Cell_____ Preferred Contact Method For Appt. Confirmation/Reminders: (Please Circle) Text Phone call **Email** Email Address :_____ Emergency Contact: Name: ______ Phone Number:_____ Primary Dental Insurance: Subscriber Name:______ Social Security Number:______ Date of Birth:______ Employer:______ Insurance Co.:_____ Insurance Co. Phone Number:_____ Group Number:_____ Subscriber ID Number: (If different from Social Security #) Relation to Patient:______ Secondary Dental Insurance: Subscriber Name: _____ Date of Birth: Social Security Number:_____ _____ Insurance Co.:_____ Insurance Co. Phone Number:_____ Group Number:_____ Subscriber ID Number: (If different from Social Security #) Relation to Patient: Insurance Authorization Statement: I hereby authorize payment directly to Amberly Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs for the dental treatment for me or my dependents. Signature: Address:______ Phone:______ Email Address:



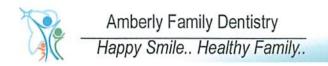
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PRINT PATIENT NAME	Birth D	ate
Other Information		
How did you hear about Amberly Family Dentistry? (Please check one or a	any that apply)	
Insurance Website Building Sign Word of Mouth Others		
What was the reason for today's visit?		
Is there anything you would like to change about your smile?		
Why did you leave your last dentist?		
		re body. Health problems that
Although dental personnel primarily treat the area in and around your re you may have, or medication that you may be taking, could have an imp you for answering the following questions.	portant interrelationship with the dent	istry you will receive. Thank
Medical History & Information		
Do you smoke or use Tobacco? Yes No Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptiv	es? 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:	CONTRACTOR PROPERTY AND ADMINISTRATION OF THE PROPERTY AND ADMINISTRATION ADMINISTRATION AND ADMINISTRATION ADMINISTRATION AND ADMINISTRATION ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION ADMINISTRATION ADMINISTRATION AND ADMINISTRATION ADMINISTRATION ADMINISTRATION AND ADMINISTRATION ADMINISTRATION AND ADMIN	
AIDS/HIV Positive	the back of this form.	Radiation Treatments
SIGNATURE OF PATIENT OR PARENT/GUARDIAN		Date
If PARENT/GUARDIAN Print Name		_

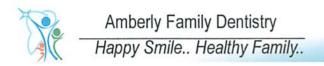
Medications INCLUDING over the counter medications and herbal supplements			
Name of Medicine	Dosage	Purpose: Why you are taking it	
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HIPAA Privacy Authorization & Patient Consent Form

Print Patient	Name	DOB
given to me und	ler the Health Insurance Portability and A	ng my protected health information. These rights are countability Act of 1996 (HIPAA). I understand that by protected health information as is required to carry out
	atment (including direct or indirect treatment)	nt by other healthcare providers involved in my
	aining payment from third party payers (i.e. day-to-day healthcare operations of Ambe	
Practices, which information, and www.AmberlyF change the term recent copy of the health informati that you are not bound to comply I understand the occurred prior to	In contains a more complete description of my rights under HIPAA. I can access family Dentistry.com or from the office is of this notice from time to time and this notice. I understand that I have the on is used and disclosed to carry out to required to agree to these requested rely with this restriction. The provided Himal Provided	directly. I understand that you reserve the right to hat I may contact you at any time to obtain the mos right to request restrictions on how my protected eatment, payment, and health care operations, but strictions. However, if you do agree, you are then a, at any time. However, any use or disclosure that
Print Name		Relationship
THIS RELEA	SE OF INFORMATION WILL REMA WRIT	IN IN EFFECT UNTIL TERMINATED BY ME IN NG.
		sages regarding my account, including but not limited using the following contact information:
Home:	Cell(Call or Text):	Email:
Signature of Pa	atient	Date
Print Name of	Guardian/Parent(If Minor)	Date
Signature of C	uardian/Parant(If Minar)	Data



PATIENT FINANCIAL POLICY

Insurance

It is our pleasure to assist you in maximizing your insurance benefit by filing your claim forms. We file insurance for you as a courtesy and do not require prepayment of procedures that are covered by your Dental Insurance. However; your co-payment will be due at the time of service. Your benefits are based on the contract between you and your insurance co. or your employer and your insurance co.

Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office.

After treatment, at the time of check out, your estimated portion is due. Please understand that the estimated portion is only an estimate, and is based upon the information available to us. When we receive payment from your insurance company or the claim is denied, it is your responsibility to pay the balance of your account.

The financial obligation for dental treatment is between you and our office. The insurance company is responsible to you and your employer, not to our office. We will assist you in any way we can. Once your dental insurance carrier has processed the claim, any difference will be due upon receipt of our statement. We accept cash, check, credit cards and Care Credit.

A \$35.00 fee will be charged for each returned check.

Unpaid balances over 60 days will incur a finance charge of 18% APR. Unpaid balances exceeding 90 days will be turned over for collection.

Late / Broken / Canceled Appointments

We understand emergencies arise, however; we will be unable to see a patient that is more than 15 minutes late for a scheduled appointment. This will be considered a broken appointment.

There may be a reason you need to reschedule an appointment. We require 24 hour notice for any rescheduled/canceled appointments.

All cancelations less than 24 hours and all broken appointments will result in a charge of \$69.00 for every hour of appointed time.

I have read and understand the above policies and agree to its terms.

nted Patient or Parent/Guardian(If Minor) Name:	
tient or Parent/Guardian(If Minor) Signature:	Date