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.

Patient Information

Name:_____
LAST FIRST MIDDLE INITIAL NICKNAME

Address:_____
STREET CITY STATE ZIP

Birth Date:_____ Social Security Number:_____

Gender: (Please Circle) Male Female Please Circle: Child Single Married Divorced Widowed

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:_____

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:_____

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:_____ Date:_____

If Patient is under 18: Responsible Party:_____ Relationship_____

Address:_____ Phone:_____

Email Address:_____

10130 Green Level Church Road, Cary, NC 27519
Email: info@amberlyfamilydentistry.com Phone: 919-467-0550 web: www.AmberlyFamilyDentistry.Com

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PRINT PATIENT NAME _____ **Birth Date** _____

Other Information

How did you hear about Amberly Family Dentistry? (Please check one or any that apply)

Insurance Website____ Building Sign ____ Word of Mouth____ Others ___ **Who should we thank today?** _____

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? _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Medical History & Information

Do you smoke or use Tobacco? Yes ____ No ____

Women: Are you Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ 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: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	~~Hay Fever~~ Allergies ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Please list any medications that you are taking on the back of this form.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health). It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN _____ Date_____

If PARENT/GUARDIAN Print Name _____

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Email: info@amberlyfamilydentistry.com Phone: 919-467-0550 web: www.AmberlyFamilyDentistry.Com

Medications INCLUDING over the counter medications and herbal supplements

Name of Medicine	Dosage	Purpose: Why you are taking it

HIPAA Privacy Authorization & Patient Consent Form

Print Patient Name_____ DOB_____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information as is required to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day-to-day healthcare operations of Amberly Family Dentistry

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health protected information, and my rights under HIPAA. I can access a copy from the website: www.AmberlyFamilyDentistry.com or from the office directly. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most recent copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

With whom (family members or friends) may we share information about your treatment and account:

Print Name_____Relationship_____

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

I consent that Amberly Family Dentistry may leave messages regarding my account, including but not limited to financial information and appointments, using the following contact information:

Home:_____ **Cell(Call or Text):**_____**Email:**_____

Signature of Patient_____Date_____

Print Name of **Guardian/Parent(If Minor)**_____Date_____

Signature of **Guardian/Parent(If Minor)** _____ Date_____

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.

Printed Patient or Parent/Guardian(If Minor) Name:_____

Patient or Parent/Guardian(If Minor) Signature:_____ Date_____

By initialing this document I Acknowledge that I received a copy: _____