Welcome to Town Square Family Dentistry

Thank you for selecting the office of Hema Srinivasan, DDS.

Our Commitment to you: Thorough evidence-based diagnosis, very competent care, excellent infection control, avoiding delay in appointments, regular follow-up and open communication.

Patient Information (Confidential)

Date: _____

Name:_____**Nickname (** _____**)** Birthday: _____ **SS** #_____

Address: _____City: _____ ZIP: _____

Phone (Home): _____ (Cell)_____

E-Mail Address: _____

Employer: _____Phone (W): _____

Full Time Student: YES_____NO_____ If yes, School Attending:_____

Emergency Contact: _____ Emergency Phone: _____
Relationship to Patient:_____

How did you hear about our office? _____

Responsible Party (If same as above leave blank)

Name:_____Relationship to Patient: _____

Address: _____Phone (Home): _____

Employer _____Phone (Work) _____

Soc. Sec. # _____ Birthday: ___ _____

Insurance Information:

Name of Insured: _____ Date Employed: _____

Insurance Company Name: _____ Group # _____

Insurance Company Address: _____

If you are covered under any other dental insurance please answer these questions

Employer: _____Insurance Company Name: _____
Group # _____

Patient Medical History

Male_____Female____

1. Physician's Name _____ Phone # _____

2. Please tell us the reason for this visit? _____ 3. Date of Last Dental Exam: _____

4. Are you under any medical treatment now? _____

5. Have you been treated with BISPHOSPHONATE drugs? (Fosamax, Aredia, Zometa, Actonel, Boniva, Reclast or Prolia)
YES____ NO____ If YES, when did the treatment begin?_____ When did treatment end?_____

6. Have you been hospitalized for any surgery or illness? _____

7. Are you currently taking any prescription drugs or medications? Yes___ No___

If yes, please list:_____

8. Do you use tobacco, alcohol or street drugs? Yes___ No___ (If yes, please circle)

9. Do you have any allergies or sensitivities to antibiotics/other drugs and medicine, local anesthetics (e.g. Novocain) or latex gloves?
If yes, please list _____

10. Women: Are you pregnant, nursing or on birth control pills? Yes_____ No_____

11. Do you have or have you had any of the following? (please circle Y or N)

High Blood Pressure	Y N	Heart Disease	Y N	Chest Pains	Y N
Heart Attack	Y N	Cardiac Pacemaker	Y N	Easily Winded	Y N
Rheumatic Fever	Y N	Heart Murmur	Y N	Stroke	Y N
Swollen Ankles	Y N	Angina	Y N	Hay Fever	Y N
Fainting/Seizures	Y N	Frequently Tired	Y N	Tuberculosis	Y N
Asthma	Y N	Anémia	Y N	Radiation Therapy	Y N
Low Blood Pressure	Y N	Emphysema	Y N	Glaucoma	Y N
Epilepsy/Convulsions	Y N	Cancer	Y N	Recent Weight Loss	Y N
Leukemia	Y N	Arthritis	Y N	Liver Disease	Y N
Diabetes	Y N	Joint Replacement	Y N	Heart Trouble	Y N
Kidney Disease	Y N	Hepatitis/Jaundice	Y N	Respiratory Problems	Y N
AIDS or HIV Infection	Y N	Thyroid Problem	Y N	Other _____	
STD	Y N	Stomach Trouble	Y N		

12. Have you taken appetite suppressants including fenfluramine or phentermine in the past 2 years? Yes____ No____

Patient Dental History

1. Do your gums bleed when you brush and floss? Y N
2. Are your teeth sensitive to hot, cold, sweet or sour? Y N _____
3. Do you feel pain in any of your teeth? Y N _____
4. Do you have any sores or lumps in your mouth? Y N _____
5. Have you had any head, neck or jaw injuries? Y N _____
6. Do you have clicking pain or difficulties with your jaw? Y N
7. Do you have frequent headaches? Y N
8. Do you clench or grind your teeth? Y N
9. Have you had prolonged bleeding? Y N
10. Have you had any prior difficulties with extractions? Y N
11. Have you had any orthodontic work (e.g. braces)? Y N
12. Are you happy with the appearance of your teeth? Y N

48 hour notice must be given for cancellation of appointments to avoid incurring a $50 broken appointment fee. 72 hour notice for **Monday** appointments.

Authorization and Release

I understand that the above information is necessary to provide me dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge
I the undersigned hereby authorize Dr. Srinivasan to take x-rays, study models, photographs or other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's needs
I also authorize Dr. Srinivasan to perform all recommended treatments mutually agreed upon by me and to use the appropriate medications and therapy indicated for such treatment. I understand that using anesthetic agents carries a certain risk.
Furthermore, I authorize and consent that Dr. Srinivasan choose and employ such assistance as deemed fit by her to provide recommended treatment.
I understand that payment is due at the time of service unless other arrangements have been made. The portion not covered by insurance is an estimation. I understand that regardless of insurance coverage all fees are the sole responsibility of the patient or the parent if he patient is a minor. I authorize insurance payments directly to Dr. Srinivasan.

_____ _____ _____
Patient (Parent or Responsible Party) Date Reviewed By