http://www.ComfortPlusFamilyDental.com/

Dr. Sudha Gutti
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Birmingham, AL 35215
205-833-5405

Patient Information

Date: ______________________ Patient Name: ____
Last, First MI (Preferred Name)

Social Security #: ________________________________ Birth Date: ______________________ Gender: FEMALE MALE

Family Status (Please circle): ☐ SINGLE ☐ MARRIED ☐ CHILD ☐ OTHER: ___________________________________

Address: ____

Contact Information

Email Address: _______________________________ Please circle how we contact you: email text message phone call

Phone (Home): ___________________ (Work): ___________________ (Cell): ___________________

Emergency Contact Name: ________________________ Relation to Patient: ____________ Phone #: ___________________

Referral Information

How did you hear about our practice? ☐ Friend/Family Name: ____

☐ Our sign ☐ Yellow Pages ☐ Internet ☐ Insurance Company ☐ Other Please list: ________________________________

Spouse or Responsible Party Information (if different from patient)

Name: ____ Relation to Patient: ________________________
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _________________________

Social Security #: _____________________________________ Birth Date: ____

Phone (Home): ____________________ (Work): ____________________ Cell: _____________________

Address: ____

Is the Responsible Party a current patient here? ☐ YES ☐ NO

Primary Insurance Information

Name of Insured: ____ Relation to Patient: ___________________
Last First MI

Insured's Birth Date: _________________ ID/Contract #: ___________________________ Group #: ____________________

Insured's Address: ____

Insured's Employer Name: ____

Insurance Plan Name: ____

Is the Insured a current patient here? ☐ YES ☐ NO

***If you have Secondary insurance, please let the receptionist know and give her copies of your card(s).**

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________
Signature of patient, parent or guardian

Patient Name: ____ Date of birth: ____________________

Health History

Allergies
- ☐ Codeine
- ☐ Penicillin
- ☐ Latex
- ☐ Other please list: ________________

____

Current Medications (include over the counter drugs, vitamins & herbs)

____
____
____
____
____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_________
- ☐ Currently Breast Feeding
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Venereal Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ____ Phone: ________________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

Dental History

- Last Dental Office: ________________________ Date of Last Dental Visit: ________________________
- Do you use any tobacco products? ☐ YES ☐ NO

Have you ever had any of the following? Please check those that apply

- ☐ Bleeding gums
- ☐ Soreness in jaws
- ☐ Sensitivity to hot/cold/sweets
- ☐ Loose teeth
- ☐ Snoring
- ☐ Bad breath
- ☐ Grinding of teeth
- ☐ Clicking sounds or pain in jaws

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain: ______________

____

- **How would you improve your smile?**

☐ Whiten my teeth ☐ Replace missing teeth ☐ Replace silver fillings with tooth colored fillings

☐ Other Please Explain: ____

- What is the most important thing to you about your dental health? ____

Consent for Services

I certify this information is correct to the best of my knowledge. I hereby consent to the dental treatment(s) that are deemed necessary for my oral health. I hereby authorize payment of the group insurance benefits otherwise payable to me directly to Sudha Gutti, D.M.D. I understand payment is due when dental services are rendered. As a condition of your treatment by this office, financial arrangements must be made in advance. I accept that I am responsible for any fees not paid by my insurance company. If I carry a balance longer than 90 days, I understand I will be charged an interest rate of 4%. I accept all fees charged as a lawful debt and promise to pay said fees including the cost of collection, attorney fees, and court costs if such are necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

I grant my permission to you or your assignee, to call me on any of the above listed numbers to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ____________ Relationship to Patient: __________________
Signature of patient, parent or guardian

____ Date: ____________ Relationship to Patient: __________________
Signature of guarantor of payment/responsible party