SMILE guru
Your Smile Perfected

Office of Keerthi Senthil DDS, MS
27700 Avenida Belleza, Cathedral City, CA - 92234, USA
760-318-4400

Today's Date: _____

Patient Information. As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your medical history in this questionnaire and there may be additional questions or forms concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Are you completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Patient Name

Last _____ Middle _____ First _____

Home Phone (include area code) _____

Mobile Phone (include area code) _____

Work Phone (include area code) _____

Address _____

City _____ State _____ Zip Code _____

Email _____

Mailing Address _____ ☐ Same as Above

City _____ State _____ Zip Code _____

Date of Birth _____ Sex M ◯ F ◯ Height _____ Weight _____

Occupation _____

Employer Name, Address _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated

Social Security Number	Emergency Contact	Relationship to Patient
_____	_____	_____
Patient Home Phone	**Patient Cell Phone**	**Preferred Pharmacy**
_____	_____	_____

Please tell us how you were referred to this office:

Physician Information. Please list all the physicians whose care you are currently under

Primary Care _____ Telephone _____

Address, City, State, Zip _____

Specialist Physician _____ Telephone _____

Address, City, State, Zip _____

Insurance Information. I certify that I or my dependents have insurance with the below listed companies and assign directly to XXXXXX Dental all insurance benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dental Insurer Company Name	Name of Insured	Their Soc. Sec. #
_____	_____	_____
Subscriber ID Number	**Group ID Number**	**Insurance Phone Number**
_____	_____	_____

Subscriber Date of Birth

_____

Medical Questions, general. Please indicate all that apply

* Do you have Diabetes? Yes ◯ No ◯ Don't Know ◯

* Do you have Heart Disease? Yes ◯ No ◯ Don't Know ◯

* Do you have any Artificial Joints or Artificial Heart Valves? Yes ◯ No ◯ Don't Know ◯

* Are you in good health? Yes ◯ No ◯ Don't Know ◯

* Have you ever had Radiation Therapy or Chemotherapy? Yes ◯ No ◯ Don't Know ◯

Are you currently under the care of a physician?

Please Name _____

Date of last physical exam _____

Any changes to your general health in the last year? Yes ◯ No ◯ Don't Know ◯

If yes, what is the condition being treated? _____

Have you had a serious illness, operation or been hospitalized in the last 5 years? Yes ◯ No ◯ Don't Know ◯

If yes, what was the illness or problem? _____

Are you taking or have recently taken prescription or over the counter medications? Yes ◯ No ◯ Don't Know ◯

If yes, please list all including vitamins, natural or herbals preparations and/ or diet supplements or anything else the Dentist should be aware of:

_____

Allergies. Please indicate all those you are or have been allergic to, and if yes please indicate your reaction

Local Anesthetics Yes ◯ No ◯ Don't Know ◯

Aspirin Yes ◯ No ◯ Don't Know ◯

Penicillin or Any Other Antibiotics Yes ◯ No ◯ Don't Know ◯

Barbiturates, Sedatives, or Sleeping Pills Yes ◯ No ◯ Don't Know ◯

Sulfa Drugs Yes ◯ No ◯ Don't Know ◯

Codeine or other Narcotics	Yes ◯ No ◯ Don't Know ◯
Metals	Yes ◯ No ◯ Don't Know ◯
Latex (rubber)	Yes ◯ No ◯ Don't Know ◯
Iodine	Yes ◯ No ◯ Don't Know ◯
Hay fever /Seasonal	Yes ◯ No ◯ Don't Know ◯
Animals	Yes ◯ No ◯ Don't Know ◯
Other	Yes ◯ No ◯ Don't Know ◯
Has a physician or dentist recommended that you take antibiotics prior to your dental treatment?	Yes ◯ No ◯ Don't Know ◯

Women Only. Are you: Pregnant?	Yes ◯ No ◯ Don't Know ◯
If YES, number of weeks: _____	
Taking Birth Control Pills/ Hormone Replace?	Yes ◯ No ◯ Don't Know ◯
Nursing?	Yes ◯ No ◯ Don't Know ◯

Tobacco, Alcohol, Other. Do you use Controlled Substances?	Yes ◯ No ◯
Do you use tobacco or nicotine, in any form?	Yes ◯ No ◯
Do you use Alcohol?	Yes ◯ No ◯
How interested are you in Stopping?	High ◯ Medium ◯ Low ◯
How much in a day _____	Times per week _____
Osteo-, Paget's, Other . Are you taking or scheduled to take either of the medications: Alendronate (Fosamax) or Risedronate (Actonel) for osteoporosis or Paget's disease?	Yes ◯ No ◯ Don't Know ◯
Since 2001, were you treated or scheduled to intravenous bisphosphonates (Aredia/ Zometa) for osteoporosis, hypercalcemia or skeletal complications from Paget	Yes ◯ No ◯ Don't Know ◯

Conditions, Diseases. Please indicate all that apply

- ☐ AIDS/ HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis / Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Atherosclerosis
- ☐ Autoimmune Disease
- ☐ Been told you Stop Breathing
- ☐ Been told you Snore
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Chemotherapy
- ☐ Cold Sores / Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Crohn's, Ulcerative Colitis
- ☐ Depression, Depressive Episodes
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells / Dizziness
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack / Failure
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure B
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Jaw Clicking, Locking
- ☐ Jaw Joint Pain
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Other Heart (congenital) Defects
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease

- ☐ Pneumonia
- ☐ Psychiatric Care
- ☐ Recent Weight loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ Teeth Grinding
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers

Please list any and all Conditions or Diseases you may have, not listed here

_____

_____

_____

* Both Doctor and Patient are encouraged to discuss any and all relevant Patient Health issues prior to treatment.

I hereby certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and staff will rely on this information for my treatment. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my Dentist nor any member of staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient _____ Date _____

Signature of Legal Guardian _____ Date _____

Office of Keerthi Senthil DDS, MS
27700 Avenida Belleza, Cathedral City, CA - 92234, USA
760-424-2150

Privacy Practices Acknowledgment

I, _____ have received a copy of the Privacy Practices from Keerthi Senthil, DDS, MS

Patient Name _____ Phone _____

Email _____

Address _____

City _____ State _____ Zip _____

Patient Signature _____ Date _____

Witness Name _____

Witness Signature _____ Date _____

Consent for Services

You have the right as a patient, to be informed about your condition and the recommended dental, medical or diagnostic procedures to be used that you make the decision whether or not to undergo the procedure after knowing the risks involved. This disclosure is meant not to alarm you rather it is simply an effort to make you better informed so you may give or withhold your consent to a procedure.

I, _____ consent to be a patient of Keerthi Senthil, DDS, MS and agree to radiographic and clinical examination. I also understand the following:

1. During the course of treatment, I may undergo procedures in all places of dentistry and medicine, including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, radiography, and saliva DNA testing.

Initials _____

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

Initials _____

3. No guarantee nor warranty can be made about treatment outcomes, restoration longevity, nor prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

Initials _____

4. I will pay in advance any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for all costs of my insurance does not cover.

Initials _____

5. My treatment plan may change over time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist and dental office staff.

Initials _____

Financial Policy

Payment is due when services are rendered. For payment options, you may apply for a payment plan through Care Credit Dental Fee Plan, which must be arranged and approved in advance of your treatment appointment. As a courtesy to our patients who have dental insurance and medical insurance coverage, we will file your claim electronically. Your deductable and co-payment are due the day of service. Any amount exceeding your plan's annual maximum amount is due when service is rendered. Please give our office at least 24 hour's notice to cancel or re-schedule an appointment.

A minimum fee of $50.00 will be charged for missed appointments. We appreciate your cooperation, Thank You.

Signature _____ Date _____