Welcome to Town Square Family Dentistry

Thank you for selecting the office of Dr. 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: _____Birth day: _____ Soc. Sec. # _____

Address: _____ _____ City: _____ZIP: _____

Phone (Home): _____ E-Mail Address: _____

Employer: _____ Phone (W): _____

Employer Address: _____

Spouse or Parent Name: _____Emergency Contact: _____

Emergency Phone: _____

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 know the following insurance information please answer these questions.

Deductible: $_____ Yearly Maximum: $_____Used to Date: $_____

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

Employer: _____Insurance Company Name: _____
Group # _____

Patient Medical History

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 hospitalized for any surgery or illness? _____

6. Are you taking any prescription drugs or medications? _____
7. Do you use (please circle) tobacco, alcohol or street drugs?

8. Do you have any allergies? _____
9. Do you have any sensitivity to local anesthetics (e.g. Novocain), antibiotics or other drugs or medicine?
_____
10. Women. Are you pregnant, nursing or on birth control pills? Y N

11. Do you have or have you had any of the following?

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	STD	Y N	Other _____	
Thyroid Problem	Y N	Stomach Trouble	Y N		

Have you taken appetite suppressants including fenfluramine or phentermine in the past 2 years? Y N
Are you allergic to latex gloves? Y N

Patient Dental History

1. Do your gums bleed when your 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?	Y N	
12. Are you happy with the appearance of your teeth?	Y N	

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