REGISTRATION

Date: _____

Patient's Name:_____How do you prefer to be addressed? _____
Sex: ☐ Male ☐ Female ☐ Other Birth Date: _____ SSN: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed E-mail Address: _____
Mailing Address:_____City:_____State:_____Zip:_____
Home Ph:_____Cell Ph:_____Work Ph: : _____
Occupation:_____Employer:_____
Responsible Party on Account (if different from above): _____
Relationship to Patient:_____Phone:_____Home Cell Work (circle one)
Responsible Party Address:_____City:_____State:_____Zip:_____
Emergency Contact:_____Relationship:_____Ph:_____
How did you hear about us (referral source)? _____
Purpose of Today's Visit? _____
How would you like to receive correspondence from our office? (Check all that apply)

☐ **TEXT MESSAGE** ☐ **EMAIL** ☐ **PHONE CALL**

DENTAL INSURANCE

PRIMARY – Policy Holder's Last Name: _____ First Name:_____Employer:_____

Birth Date:_____Insurance Phone #:_____Relationship to Patient: _____
Ins. Provider:_____Member/Subscriber ID/SSN:_____Group #: _____
SECONDARY – Policy Holder's Last Name:_____First Name:_____ Employer:_____
Birth Date:_____Insurance Phone #:_____Relationship to Patient:_____
Ins. Provider:_____Member/Subscriber ID:_____Group #: _____

Patient Consent

1. I authorize Dr. Karri and Associates at Serene Dental to take x-rays, photos, study models and other diagnostic aids as needed to make a thorough diagnosis. I authorize that such diagnostic material may be released to third-party payors and\or other health professionals.
2. I authorize the use of needed anesthetics, sedatives, and other medication. I am aware that this involves some risks, including but not limited to redness and swelling of tissues, pain , miscarriage, itching, vomiting, dizziness, cardiac arrest, drowsiness, and \ or lack of coordination.
3. I understand that your staff members work hard to provide educated quotes based on the information provided by insurance companies. However final payment is in the hands of insurance processors not yours. I am responsible for payment for all services rendered on my behalf.
4. I authorize the Practice to submit claims for services rendered to my insurance company on my behalf and have insurance payments sent directly to Shilpa Karri DDS. I recognize that I am ultimately responsible for understanding my insurance benefits and **if, for any reason, my insurance company does not remit the estimated amount, I agree to pay the balance of my account.**
5. I authorize the Practice to release to staff, hospitals, other health care providers, and insurance companies, self - insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
6. I give my consent for the Practice to use before and after photographs of myself and my dental treatment for their business or promotional materials.

Please read the following agreement carefully and agree to terms and conditions:

X_____

Patient Signature (Parent/Guardian Signature if Patient is under 18)

New Patient Appointment

I understand that I am anew patient at Serene Dental. The following procedures will be performed at my first visit

Complete New patient Oral/ Perio evaluation X_ Periodontal screening X_ oral cancer screening X Prophy or cleaning or full mouth debridement X All necessary X-rays / radiographs/ photographs of treatment X

Patient initials: ____

Please note that we believe in the benefit of fluoride treatment after preventive care. The American dental association has continuously endorsed the use of fluoride containing products as safe and effective measures for preventing tooth decay. But vast majority of insurance companies do not cover this expense for adults. We believe the benefits of fluoride outweigh the minimal cost of $20 for this application. You as a patient have the right to decide on this benefit. Please initial below on the acceptance or decline of this highly beneficial fluoride treatment. If you are parent or guardian of a patient under the age of 18, please initial below on their behalf

Acceptance Initials: _____ Decline Initial _____

Drugs and Medications

I understand that antibiotics, analgesics, nitrous oxide, antibiotic pre-med, oral conscious sedation meds and other of anesthesia medications administered by our doctors can cause allergic reaction causing redness, bruising and swelling of tissue in the mouth and / or on the facial tissue, pain, itching, vomiting and / or anaphylactic shock(severe allergic reaction) which may require hospitalization at the cost of the patient. I also understand that our doctors will bade his professional administration of drugs & medications based on the medical history and drug allergy information provided by me on the patient information form. I absolve all members / employees of Serene Dental of all responsibility if medication is not taken as prescribed. I agree not to operate motor vehicle or hazardous device for at least 24 hrs. or more until fully recovered from the effects of the anesthesia or drugs prescribed for my care

Female Patients: It has also been explained to me and I understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed.

Patient initials: _____

Changes in treatment plan:

I understand that during treatment it may be necessary to change add or delete procedures because of the conditions found while working on the teeth that were not able to be discovered during our oral and X-ray examination, the most common being root canal therapy following routine restrictive procedures(i.e Fillings, crowns etc). I give my permission and trust to the treating doctor to make any or all changes and additions as necessary for the best interest of my dental health. Fees for additional procedure will apply and I will be responsible for that additional cost.

Note: X-rays may need to be taken before, during and / or after treatment per your insurance coverage or in-office document, these x-rays are required by the insurance companies to obtain your coverage, most insurance companies cover this additional cost but if your insurance does not cover this cost, you are responsible for the fees involved in obtaining these required x-rays.

Patient initials: _____

Serene Dental Cancellation and Broken Appointment Policy

We understand that illness, emergencies, bad traffic, flat tires and bad weather do occur. We ask our patients to give us 48hrs notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and Fees:

- Cancellation or rescheduling of an appointment with a notification of 48hrs or more – No charge
- Cancellation or rescheduling of an appointment less than 48hrs and upto 24hrs may or may not be considered a broken appointment, it will be our discretion.
- Failure to give 24hr advance notice to cancel or reschedule an appointment or not showing up for appointment without notice is considered "broken appointment"
- We allow for one broken appointment in a 12-month period
- Any additional broken appointments within a 12-month period will be charged a fee of $25 for routine cleanings and $50 for any dental treatment

Our goal is to maintain your dental health and to keep the cost of dental services as economical as possible. The appointment you schedule is reserved for you and your treatment only. If you fail to keep your appointment without providing us adequate notice, tis adds to overall cost of care as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concern, never hesitate to ask us.

I have read and understood the above-mentioned policy.

Patient Name (Print):_____

Patient Signature (Parent/Guardian if Minor): _____ Date: _____

EMAIL CONSENT

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties.

However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide

Include the check boxes for three statements:

☐ I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is

☐ I consent to only receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My email address is

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Patient Name (Printed): _____

Patient/Parent/Guardian Signature_____ Date: _____