Merritt Dental Care LLC
Dr. Prasanna Ravuri
Patient Registration Form

Personal Information   Date: ___________________________

First Name: ____________________________ MI: ________ Last Name: __________________________________

☐ Male ☐ Female Date of Birth: __________________________ Social Security #: ________________________

Street: ________________________________ City: ______________ State: ___ Zip: ______

Home Phone_____________________ Work Phone: __________________ Cell Phone______________________

E-mail: _______________________ Employer: ___________________ Occupation: ___________________

How would you like us to contact you for appointment confirmation? ☐ Telephone ☐ Text ☐ E-mail

Marital Status: ☐ Single ☐ **Married** ☐ Divorced ☐ **Separated** ☐ Domestic Partner

Who should we thank for referring you? ____

Primary Dental Insurance

Carrier Name: ____________________________________

Subscriber Name: _________________________________

Subscriber Date of Birth: ___________________________

Employer: _______________________________________

ID: ____________________ Group#: ________________

Secondary Dental Insurance

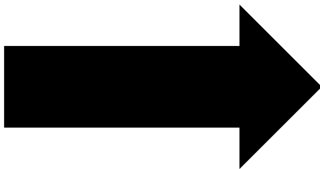
Carrier Name: _____________________________

Subscriber Name: __________________________

Subscriber Date of Birth: ______________________

Employer: ________________________________

ID: ________________Group#: _______________

In case of an emergency, who should we contact? 	Name: ____________________ Address: ____________________ Relationship: ____________________ Telephone: ____________________

Signature____ **Date**_______________

Merritt Dental Care LLC

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY)

Bad Breath
Bleeding Gums
Grinding teeth
Lip, Cheek or Nail Biting
Loose Teeth or Broken Filling/ Tooth
Orthodontic Treatment
Pain Around Ear or Jaw
Periodontal Disease
Sensitivity to Cold, Heat or Sweets
Sensitivity when Biting
Head or Neck Injuries
Jaw Difficulty or Clicking
Tooth Pain
Blisters on Lips or in Mouth

HOW OFTEN DO YOU BRUSH? ____________________ **HOW OFTEN DO YOU FLOSS?** __________________

DATE OF LAST DENTAL X-RAY? ____________________ **DATE OF LAST DENTAL CLEANING?** _____________

Medications: (Prescriptions and non-prescription medications, vitamins, birth control, herbs, & Supplements)

Medication	Dose	Frequency	Medication	Dose	Frequency

Drug Allergies or Reactions to Medications/ Food/ Other Agents list below Yes ☐ NO ☐

LIST HERE: ____

____

PERSONAL MEDICAL HISTORY: Do you have any of the following? PLEASE CIRCLE

Heart Defects (list below)
Cancer (List Below)
High Blood Pressure
Thyroid problems
Atrial fibrillation
Pacemaker
Diabetes
Cholesterol Problems
Alcoholism
AIDS, HIV, Herpes or Cold Sores
Arthritis
Anxiety or other Emotional Conditions
Diabetes
Migraines
Allergies
Anemia or Blood Disorders (list below)
Artificial Joint or Valve
Depression
Asthma
Acid Reflux (heart burn)
Epilepsy, Seizures, or Fainting Spells
Hepatitis or other liver disease
Pregnancy Due Date ___________________

LIST HERE: ____

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and as my responsibility to inform this office of any

changes.
Signature of Patient or Guardian: ______________________________________ Date: __________________

Merritt Dental Care LLC

Dr. Prasanna Ravuri

PLEASE READ THIS FORM CAREFULLY!!!

Fees & Payments: If you have insurance, we will gladly process your claim. We request that you pay your ESTIMATED portion when services are rendered. Any amount not covered by your insurance or any difference in the estimated portion is the patient's or guardian's responsibility. Our office will file your insurance a maximum of two times per appointment. If the claim is not paid by your insurance carrier within 45 days, you will be responsible for the full balance and any further insurance appeal is your responsibility. We will be happy to provide you with a claim form so that you can follow up on your insurance claims personally. **WE CAN ONLY ESTIMATE PAYMENT FROM YOUR INSURANCE COMPANY. IT IS YOUR RESONSIBILITY TO PAY ANY DEDUCTIBLE, COINSURANCE, AS WELL AS ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE COMPANY**.

Returned Checks: There is a **$30.00** fee for returned checks. You will be responsible for all collection coats, Attorney fees, and court costs.

Missed appointment fee: We require that you provide **48 hours'** notice if you need to cancel an appointment. If you break two appointments in a twelve-month period without providing 48 hours' notice you agree to pay a **$50.00** late fee.

Saturday appointment fee: We require that you provide **72 hours'** notice if you need to cancel a Saturday appointment. If you break one Saturday appointment without providing **72 hours'** notice you agree to pay a **$75.00** cancelation fee. When scheduling a Saturday appointment, we will request a credit card on file.

Late Payment Fees & Finance Charges: Failure to pay the bill within **90** days may result in the assessment of late payment fees, finance charges, or being sent to collections. These charges may be assessed each month that the account has an overdue, outstanding balance.

The signature on file is my authorization for release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature____ Date_____________

Hippa A Notice of Privacy Practices (located at front Desk)

Merritt Dental Care LLC
Dr. Prasanna Ravuri

999 Summer St, #306
Stamford, CT 06905
(203) 356-9990

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You May Refuse to Sign This Acknowledgment**

I, ____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify):