

Maneesha Chigurupati DDS

117 KERNEYWOOD STREET
LAKELAND, FL 33803
PHONE: (863)687-2759

DATE: _____

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ PREFERRED NAME: _____
DATE OF BIRTH: _____ SOCIAL SECURITY # _____ - _____ - _____ MALE FEMALE
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
PREFERRED PHONE #: _____ RECEIVE CORRESPONDENCE VIA TEXT EMAIL
E-MAIL ADDRESS: _____ OCCUPATION: _____
EMERGENCY CONTACT: _____ RELATION: _____
EMERGENCY PHONE #: _____

PREFERRED PHARMACY

PHARMACY NAME: _____ PHONE #: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION

<p>PRIMARY DENTAL INSURANCE</p> <p>IS SUBSCRIBER THE SAME AS PATIENT? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>SUBSCRIBER INFORMATION</p> <p>FIRST NAME: _____</p> <p>LAST NAME: _____</p> <p>DATE OF BIRTH: _____</p> <p>INSURANCE COMPANY</p> <p>NAME: _____</p> <p>SUBSCRIBER ID: _____</p> <p>GROUP #: _____</p> <p>PATIENT RELATIONSHIP TO SUBSCRIBER</p> <p><input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER: _____</p>	<p>SECONDARY DENTAL INSURANCE (IF APPLICABLE)</p> <p>IS SUBSCRIBER THE SAME AS PATIENT? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>SUBSCRIBER INFORMATION</p> <p>FIRST NAME: _____</p> <p>LAST NAME: _____</p> <p>DATE OF BIRTH: _____</p> <p>INSURANCE COMPANY</p> <p>NAME: _____</p> <p>SUBSCRIBER ID: _____</p> <p>GROUP #: _____</p> <p>PATIENT RELATIONSHIP TO SUBSCRIBER</p> <p><input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER: _____</p>
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RESPONSIBLE PARTY (other than the patient)

FIRST NAME: _____ LAST NAME: _____
DATE OF BIRTH: _____ SOCIAL SECURITY # _____ - _____ - _____ MALE FEMALE
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____

RESPONSIBLE PARTY SIGNATURE: _____ DATE: ____/____/____

NAME: _____

DATE: _____

HEALTH HISTORY UPDATE

REASON FOR VISIT: BROKEN TOOTH CHECK-UP COSMETIC DENTURES TOOTH PAIN
 OTHER: _____

ARE YOU UNDER THE CARE OF A PRIMARY CARE PHYSICIAN? YES NO DATE OF LAST PHYSICAL: _____

PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE #: _____

ARE YOU TAKING OR HAVE YOU TAKEN ANY STEROID/CORTISONE THERAPY IN THE LAST 2 YEARS? YES NO

ARE YOU TAKING OR HAVE YOU TAKEN ORAL BISPHOSPHONATES (E.G., FOSAMAX, BONIVA) OR IV BISPHOSPHONATES, (E.G., ZOMETA, AREDIA, PROLIA)? YES NO HOW LONG? _____

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL PROCEDURES? YES NO

ARE YOU ALLERGIC OR HAVE YOU HAD AN ADVERSE REACTION TO ANY OF THE FOLLOWING?

NONE AMOXICILLIN ASPIRIN CODEINE EPINEPHRINE LATEX METALS ANESTHESIA
 PENICILLIN SULFA TETRACYCLINE OTHER: _____

LIST ANY MEDICATIONS YOU ARE TAKING INCLUDING NON-PRESCRIPTION DRUGS AND HERBALS/VITAMINS:

CHECK ANY CONDITIONS THAT APPLY TO YOU

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> DEMENTIA | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HIV | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> ALLERGIES OR HIVES | <input type="checkbox"/> DIALYSIS | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> STD |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DRUG ADDICTION | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> STOMACH PROBLEMS |
| <input type="checkbox"/> ARTIFICIAL JOINT/PINS | <input type="checkbox"/> EXCESSIVE BLEEDING | <input type="checkbox"/> LUNG DISEASE/COPD | <input type="checkbox"/> STROKE |
| TYPE: _____ | <input type="checkbox"/> FAINTING/DIZZINESS | <input type="checkbox"/> LUPUS | <input type="checkbox"/> THYROID DISEASE |
| AGE: _____ | <input type="checkbox"/> GERD/ACID REFLUX | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> TUBERCULOSIS (TB) |
| <input type="checkbox"/> ASPIRIN THERAPY | <input type="checkbox"/> HEARING IMPAIRMENT | <input type="checkbox"/> MOBILITY IMPAIRMENT | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> VISUAL IMPAIRMENT |
| <input type="checkbox"/> BLOOD THINNER | <input type="checkbox"/> HEART SURGERY | <input type="checkbox"/> PACE MAKER | <input type="checkbox"/> CANCER TYPE: |
| <input type="checkbox"/> BLOOD TRANSFUSION | DATE: _____ | <input type="checkbox"/> PSYCHIATRIC CARE | _____ |
| <input type="checkbox"/> BREATHING PROBLEMS | <input type="checkbox"/> HEART TROUBLE | | _____ |
| <input type="checkbox"/> OTHER ILLNESS | TYPE: _____ | | |
| TYPE: _____ | <input type="checkbox"/> HEPATITIS | | |

PATIENT SIGNATURE: _____

DATE: _____

DENTAL HISTORY

DATE OF LAST DENTAL VISIT: I DON'T KNOW EXACT DATE LAST 6 MONTHS 6 MONTHS – 1 YEAR 1 – 3 YEARS
 GREATER THAN 4 YEARS NEVER

DATE OF LAST DENTAL X-RAY: I DON'T KNOW EXACT DATE LAST 6 MONTHS 6 MONTHS – 1 YEAR 1 – 3 YEARS
 GREATER THAN 4 YEARS NEVER

ORAL HEALTH

HAVE YOU EVER BEEN TREATED FOR PERIODONTAL (GUM) DISEASE? YES NO

HAVE YOU EVER HAD NOVOCAINE OR OTHER LOCAL ANESTHETIC? YES NO

HOW HAPPY ARE YOU WITH YOUR SMILE (1-10)? _____

ARE YOU CURRENTLY WEARING DENTURES? YES NO

AGE OF DENTURES: LESS THAN 6 MONTHS 6 MONTHS – 1 YEAR 1 – 3 YEARS GREATER THAN 4 YEARS

PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU BELOW

PAIN IN JAW (TMJ) DIFFICULTY CHEWING/SWALLOWING USE TOBACCO PRODUCTS MOUTH SORES
 BROKEN/LOOSE TEETH TEETH GRINDING/CLENCHING SWOLLEN/BLEEDING GUMS SENSITIVE TEETH

DO YOU WISH TO SPEAK TO THE DENTIST IN PRIVATE? YES NO

WOMEN PATIENTS ONLY

ARE YOU CURRENTLY PREGNANT? YES NO ESTIMATED DELIVERY DATE: _____

ARE YOU NURSING? YES NO ARE YOU TAKING ANY BIRTH CONTROL PRESCRIPTIONS? YES NO

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS AND ACKNOWLEDGE THAT QUESTIONS HAVE BEEN ANSWERED TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE MY CONSENT TO THE DENTIST TO PERFORM AN EXAMINATION AND DIAGNOSE MY CONDITION. I ALSO GIVE MY CONSENT FOR ANY PREVENTATIVE OR BASIC RESTORATIVE PROCEDURES WHICH MAY BE NECESSARY. I UNDERSTAND THAT THIS CONSENT WILL REMAIN IN EFFECT UNTIL TREATMENT IS TERMINATED EITHER BY ME OR THE DENTIST.

PATIENT'S SIGNATURE: _____ DATE / / _____

Maneesha Chigurupati D.D.S.

117 Kerneywood Street

Lakeland, FL 33803

863-687-2759

FINANCIAL POLICY

Please take a moment to read the following information regarding our financial policy.

- All patients must complete required forms prior to receiving treatment.
- We accept cash, check, any of the major credit cards (Visa, MC, American express, Discover), or Care Credit at the time dental treatment is provided.
- Minors must be accompanied by a parent or guardian unless prior arrangements have been made and the parent or guardian has accepted treatment on the minor's behalf in advance. The person who accompanies a minor/child to the appointment will be considered the responsible party and, therefore, is responsible for any payment due at the time service is rendered.

Dental Insurance

- As a courtesy for our patients with dental insurance, we will help you estimate how much you can expect your insurance to pay, and we will submit your claim to your dental insurance company. We can file most insurances, including PPO plans. **WE DO NOT ACCEPT ANY HMO PLAN.**
- Any portion not expected to be covered by your insurance is your responsibility and is due at the time treatment is provided. This includes deductibles and co-payments.
- Please understand that we cannot predict exactly how much your insurance company will pay and there is no guarantee of any payment by them. If after 90 days your insurance company has not paid its portion, the patient will be responsible for paying the balance in full.
- If you or your family exceed the annual limitations in any plan year, you will be responsible for the full amount of dental services. The patient is responsible for any charges that are not covered by your insurance.
- Please remember that we provide dental care to you, our patient, not the insurance company. If you have any questions regarding your insurance benefits, please don't hesitate to call our office to discuss your concerns.
- If you have secondary insurance, we will gladly provide the information you need to file the claim so that you can be reimbursed by your secondary insurance carrier. Being a small office, we cannot carry open balances while waiting for the second insurance payment. The patient is responsible for any amounts the secondary insurance may pay in addition to portions not covered by primary insurance.
- Pre-treatment estimates are not automatically filed, but we are happy to send one at the patient's request.
- Insurance companies say they will cover "Usual and Customary" (UCR) fees. However, most insurances have failed to keep their UCR fee schedules up to date. We are committed to keeping our fees as low as possible so that our patients can afford the treatment they need. If our fee differs from your insurance 'UCR' fee, you are responsible for the difference.
- If you have dental benefits, please bring your card and benefit information, so we may file to your insurance company. We work with most insurance, but HMO plans are not accepted, nor can we file a claim for an HMO policy. Please do not hesitate to call us prior to your appointment if you

have any questions. Again, thank you for choosing our office. We look forward to a lifetime of continuing care.

Additional Information

- Accounts unpaid for 90 days from date of service are subject to monthly late fees (\$35 per month) and finance charges (1.5% monthly).
- If your account is 90 days past due, you may be sent to a collection agency and you will be responsible for any additional collection fees.
- Missed appointments and cancellations with less than 24 hrs notice are subject to a cancellation fee of \$25.
- Payment returned to us from your bank due to insufficient funds are subject to a \$40 NSF fee.

Signature of Patient or Parent/Guardian

Date

FAMILY DENTISTRY OF LAKELAND

Appointment Confirmation Policy

We're committed to making your dental experience smooth and stress-free!

To ensure you never miss a visit, we've created a simple, automated reminder system:

1. Initial Confirmation

Once your appointment is booked, you'll receive a "Save the Date" email and/or text to confirm your reservation.

2. First Reminder – 14 Days Before Your Appointment

You'll receive a friendly reminder via email and/or text.

Reply with:

"C" to Confirm

"P" if you prefer a personal call from our team.

3. Second Reminder – 1 week phone call to every unconfirmed patient

4. Third Reminder

A) 3 DAYS Prior

A second reminder will be sent by email and/ or text.

Please reply:

"C" to confirm, or

"P" if you'd like us to call.

*****Important: Please confirm to avoid a cancellation fee for missed appointments. Please call us by 10:00 am next business day.**

B) IF WE STILL HAVE NOT HEARD FROM YOU 48 hours prior – WE RESERVE THE RIGHT TO RESCHEDULE OR CANCEL your appointment.

5. Final Reminder – 1 Hour Before

We'll send a brief message to let you know:

"We look forward to seeing you in 1 hour. Your time is reserved with us!"

*****Repeat cancellations will be charged \$25.00 for no shows or cancelling less than 24 hours**

******\$50 Reservation fee required for multiple cancellations on TREATMENT (collect prior to making next appt)**

Need to Reschedule?

We understand things come up! Just give us a call-in advance so we can assist you and offer your time to another patient in need. REMINDER THERE IS A \$25.00 CANCELLATION FEE FOR APPOINTMENTS BROKEN LESS THAN 24 HOURS!

Thank you for choosing Family Dentistry of Lakeland. We look forward to seeing your smile soon!

Initials _____

Email and Text Messaging Program Patient Information Form

We provide our patients the option to participate in our online patient communication system.

Some of the system features allow you the ability to:

- Request Appointments via Email
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Customer Satisfaction Surveys
- Refer Your Friends Online

You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email, or by replying to a text message with 'STOP'. Standard text messaging rates apply.

Please Update Your Contact Information

Name: _____
Address: _____
City: _____
State: _____
Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____ Opt in to text messages
Email: _____ Opt in to email

Please sign below to indicate that you agree to allow us to use this information in providing your services.

Signature

Date

NOTICE OF PRIVACY PRACTICES

Family Dentistry of Lakeland
Effective Date: April 24, 2026

Our Commitment to Your Privacy

At Family Dentistry of Lakeland, protecting your personal health information is very important to us. We are required by law to maintain the privacy of your protected health information (PHI), provide you with this notice of our legal duties and privacy practices, and follow the terms of the notice currently in effect.

How We May Use and Disclose Your Health Information

Treatment

We may use and disclose your health information to provide, coordinate, or manage your dental care. This includes sharing information with dentists, specialists, laboratories, physicians, pharmacies, and other healthcare providers involved in your treatment.

Payment

We may use and disclose your information to bill and collect payment from you, your insurance company, or a third party.

Healthcare Operations

We may use your information for practice operations such as quality assessment, staff training, licensing, accreditation, and administrative purposes.

Appointment Reminders and Communications

We may contact you by phone, voicemail, text message, email, or mail regarding appointment reminders, treatment follow-up, insurance matters, and general office communications.

Text and Email Consent

By providing your phone number or email address, you consent to receive appointment reminders, scheduling notices, treatment communications, and billing notifications electronically. Standard messaging and data rates may apply. You may withdraw your consent at any time by notifying our office.

Treatment Alternatives and Practice Updates

We may inform you about treatment options, preventive care, or other dental services that may benefit your oral health.

Special Protection for Certain Records

Some health information may be subject to additional federal confidentiality protections, including records related to substance use disorder treatment under 42 CFR Part 2. When these protections apply, we may be more limited in how we use or disclose this information. These records generally require written patient consent and cannot be used in legal proceedings without authorization or a valid court order.

Online Reviews and Communication Preferences

We may request feedback regarding your experience with our office. Participation in online reviews is voluntary. We will never disclose protected health information in response to public reviews or online comments.

Your Rights as a Patient

You have the right to:

- Request a copy of your health records (including electronic copies)
 - Request corrections to your records
 - Request restrictions on certain uses and disclosures
 - Request confidential communications
 - Receive an accounting of disclosures
 - Obtain a paper copy of this notice at any time
-

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services Office for Civil Rights. You will not be penalized for filing a complaint.

Privacy Contact

Privacy Officer: Jennifer Gregory

Phone: 863-687-2759

Address: 117 Kerneywood St, Lakeland, FL 33803

Changes to This Notice

We reserve the right to revise this notice and make the revised terms effective for all protected health information we maintain.

Patient Acknowledgment of Receipt

Patient Name: _____

Date: _____

Signature: _____