ANCHOR
PERIODONTICS
Periodontal & Implant Center

PATIENT INTAKE FORM

Ranjitha Krishna, D.M.D

PATIENT NAME: _____ **PREFERRED NAME:** _____

REFERRED BY: _____ **DATE OF BIRTH**: _____/_____/_____

GENDER: _____ HEIGHT: _____ WEIGHT: _____

HOME ADDRESS: _____

PHONE NUMBER: _____(C) _____(H) EMAIL: _____

EMERGENCY CONTACT: _____ PHONE: _____

OCCUPATION: _____ SSN: _____

PREFERRED PHARMACY: _____ PHARMACY PHONE: _____

PHARMACY ADDRESS: _____

DENTAL INSURANCE

INSURANCE COMPANY: _____ PHONE: _____

ID NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER SSN: _____

DENTAL INFORMATION

WHAT IS YOUR MAIN CONCERN FOR TODAY'S VISIT? _____

ARE YOU EXPERIENCING ANY PAIN IN YOUR MOUTH AT THIS TIME? YES_____ NO_____

GENERAL DENTIST: _____ PHONE: _____

CIRCLE ALL OF THE WORDS THAT APPLY TO YOU

BLEEDING GUMS SORE GUMS SENSITIVE GUMS GUM RECESSION INTERESTED IN IMPLANTS

ANY OTHER CONCERNS? _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ DO YOU USE DENTAL FLOSS_____

HOW OFTEN DO YOU GET YOUR TEETH CLEANED? _____ DATE OF LAST CLEANING_____

DO YOU CLENCH/GRIND YOUR TEETH? YES_____ NO_____ IF SO, WHEN? _____

HAVE YOU EVER BEEN TREATED FOR GUM DISEASE BEFORE? YES_____ NO_____

IF SO, WHEN? _____ BY WHOM? _____

121 Vann Street NE Suite 201, Marietta, GA 30060 Phone: (770) 422-5220 Fax: (678) 253-6502
www.anchorperio.com

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MEDICAL HISTORY

PLEASE INDICATE WITH AN (X) ANY ALLERGIES OR REACTION TO THE FOLLOWING:

___**LOCAL ANESTHETICS/NOVACAINE**	___**PHENERGAN**	___**SULFA**	___**OTHER**
___**EPINEPHRINE**	___**VALIUM**	___**CODEINE**	_____
___**PENICILLIN**	___**MOTRIN**	___**DEMEROL**	_____
___**ERYTHROMYCIN**	___**ASPIRIN**	___**ALCOHOL**	_____
___**TETRACYCLINE**	___**TYLENOL**	___**LATEX**	_____

DO YOU PRE-MEDICATE WITH ANTIBIOTICS PRIOR TO DENTAL PROCEDURES? YES___ NO___

IF SO, FOR WHAT REASON? _____

HAVE YOU HAD ANY JOINT REPLACEMENTS? YES___ NO___ WHEN? _____

HEART CONDITION? YES___ NO___ WHAT CONDITION? _____

ARE YOU CURRENTLY PREGNANT? YES___ NO___

DO YOU USE TOBACCO PRODUCTS? IF SO, WHAT KIND AND HOW MUCH? _____

PRIMARY CARE DOCTOR: _____PHONE NUMBER: _____

HAVE YOU BEEN DIAGNOSED WITH ANY HEALTH CONDITIONS FOR WHICH YOU ARE RECEIVING TREATMENT? IF YES, PROVIDE DETAILS. _____

PLEASE LIST THE NAME AND NUMBER OF ANY SPECIALIST YOU SEE REGULARLY:

_____

PLEASE INDICATE WITH AN (X) IF YOU CURRENTLY HAVE, OR HAVE EVER BEEN TREATED FOR:

_____**HEART DISEASE**	_____**ASTHMA/LUNG DISEASE**	_____**GLAUCOMA**
_____**HEART MURMUR**	_____**KIDNEY/BLADDER PROBLEMS**	_____**A.I.D.S**
_____**VENERIAL DISEASE**	_____**RHEUMATIC FEVER**	_____**CANCER**
_____**BLEEDING PROBLEMS**	_____**ULCERS OR COLITIS**	_____**EPILEPSY**
_____**STROKE**	_____**LIVER PROBLEMS/HEPATITIS**	_____**PACEMAKER**
_____**CHEMOTHERAPY**	_____**DIABETES**	_____**JOINT REPLACEMENT**
_____**BLOOD THINNER**	_____**HIGH/LOW BLOOD PRESSURE**	_____**ANGINA**
_____**PSYCIATRIC TREATMENT**	_____**MITRAL VALVE PROLAPSE**	

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING _____

_____

IS THERE ANY OTHER INFORMATION OR CONDITION CONCERNING YOUR MEDICAL OR DENTAL HISTORY NOT MENTIONED ABOVE? YES_____ NO_____

PLEASE EXPLAIN_____

PATIENT SIGNATURE_____ **DATE**_____

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Patient Office Policies

Appointments

At Anchor Periodontics, we understand that circumstances can change, and appointments may need to be rescheduled. To ensure efficient scheduling and to respect the time of our staff and other patients, we have established the following cancellation policy.

- Appointment Cancellations: We require at least 48 hours' notice for any cancellations or rescheduling of exam or routine hygiene appointments. Cancellations made within 48 hours of the scheduled appointment will incur a **fee of $50**.
- Surgical & SRP Procedure Cancellations: We require at least 5 days' notice for any cancellation or rescheduling of Surgical and SRP (scaling and root planing) appointments. These missed appointments or cancellations will incur a **fee of $150**.
- Late Arrivals: Arriving late may result in a shortened appointment or rescheduling. Patients may still be subject to a fee if they do not provide adequate notice.
- Payment of Fees: Cancellation fees will be billed to the patient's account and must be settled before scheduling future appointments.

Insurance & Billing

At Anchor Periodontics, we strive to provide transparent and accessible dental care. Below are our policies regarding insurance and billing.

- Insurance: We are happy to work with most major dental insurance plans and will submit claims on your behalf. However, your insurance is a contract between you and your insurance company. Patients are responsible for knowing their benefits, including: annual maximums, deductibles, frequency limitations and non-covered services. We will provide a treatment plan with estimated insurance coverage and patient responsibility. Estimates are based on the information provided by your insurance at the time and are not a guarantee of payment.
- Payment: Payment is due at the time services are rendered. We accept Cash, Credit/Debit Cards, HSA/FSA Cards, Care Credit, and Cherry
- Deposits for Surgical Procedures: A deposit is required for all surgical procedures. The deposit amount will be communicated to you during the consultation. This deposit will be applied to the overall cost of the procedure.
- Outstanding Balances: Patients are responsible for any balances due after insurance payments have been processed. Statements will be sent for any outstanding amounts, and prompt payment is appreciated. All outstanding balances will need to be settled before receiving any additional treatment.

Minors

At Anchor Periodontics, the safety and well-being of our patients, especially minors, are of the utmost importance. This policy outlines the guidelines for treatment of patients under the age of 18.

- All minor patients (under 18) must be accompanied by a parent or legal guardian.
- The accompanying adult must present a valid photo ID (e.g., driver's license, passport).
- Providers will assess the minor's understanding of the procedures and treatments being performed, ensuring they comprehend the information in an age-appropriate manner.
- The parent or guardian will need to review and sign consent forms for treatment before care begins.

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- If a parent or guardian cannot attend, written consent with a copy of their photo ID is required beforehand.
- Parents and guardians are encouraged to provide feedback or express any concerns regarding treatment of their minors.

Patient Rights & Responsibilities

At Anchor Periodontics, we are committed to providing our patients with exceptional care and a positive healthcare experience. Our Patient Rights and Responsibilities Policy outlines the rights you hold as a patient, along with you responsibilities in the healthcare process.

- Patients have the right to receive courteous and respectful treatment in a safe environment.
- Patients have the right to be informed about their diagnosis, treatment options and the risk and benefits of procedures.
- Patients have the right to timely access to dental care and services.
- Patients have the right to privacy regarding their medical records and personal health information.
- Patients can express concerns or complaints regarding their care without fear of retaliation.
- Patients are responsible for providing complete and accurate information to facilitate effective care.
- Patients are responsible for following their agreed upon treatment plans with their provider.
- Patients are responsible and encouraged to ask questions if they do not understand their diagnosis.

Conduct

This policy aims to maintain a safe and professional environment while providing clear guidelines for both patients and staff regarding acceptable behavior.

All patients and guests are expected to treat our staff and other patients with respect and courtesy.

- Definition of Poor Conduct: Poor conduct includes, but is not limited to; verbal abuse or threatening behavior toward staff or other patients. Use of curse words, foul language or any form of abusive language directed at staff or other patients. Disrespectful or disruptive behavior in the waiting area or treatment rooms. Non-compliance with treatment plans or office policies. Repeatedly arriving late or failing to show up for scheduled appointments without proper notice.
- Procedure for Patient Dismissal: Patients will receive a verbal warning for minor infractions, informing them of the behavior that is unacceptable and the potential consequences of continued poor conduct. If poor conduct persists, the patient will receive written notice informing them of their dismissal. The practice will ensure that all communications regarding dismissal are conducted professionally and respectfully.
- Emergency Situations: In cases of severe misconduct (e.g., threats of violence), the patient may be dismissed immediately without prior warning.

Print Name of Patient: _____

Signature Patient/Guardian: _____

Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. By signing this form, you consent to our use and disclosure of your protected health insurance to carry out treatment, insurance claims, payment activities and healthcare operations. You will have the right to revoke this consent at any time by submitting to our office written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating if you revoke this consent.

Indicated below are names of any Person(s) to whom I would like Anchor Periodontics to allow disclosure of individually identifiable Health Information Health Information (IIHI). (Optional)

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Printed Name: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY

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

- **Individual refused to sign**
- **Communications barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (Please Specify): _____**

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATIONS

I agree that the dental practice may communicate with me electronically at the email address below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by sending written notice to our office.

Email Address: _____

Signature: _____ Date: _____

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Patient Photo Consent

Patient Name: _____Date of Birth: _____

I, _____ (patient or parent/guardian if minor), understand that Anchor Periodontics may take photographs and/or videos for purposes related to my dental care and the operation of the practice.

Please **check ONE option below**:

☐ **I CONSENT** to Anchor Periodontics taking and using photographs and/or videos of me/my child for the following purposes (as applicable):

- Clinical records and documentation
- Patient education
- Marketing materials (including website, social media, brochures)
- Office displays

☐ **I DO NOT CONSENT** to the use of photographs and/or videos of me/my child for any purpose other than what is required for my dental treatment and clinical records.

Acknowledgment

- I understand that images used for purposes beyond clinical records will not include my name or identifying information unless I provide separate written authorization.
- I understand that granting or refusing consent will **not affect the quality of care** I receive.
- If I consent, I understand that I may withdraw my consent at any time by notifying the office in writing.

Signature: _____Date: _____

If minor:
Parent/Guardian Name: _____
Parent/Guardian Signature: _____