A note from Jenn:

Please fill out the enclosed packet in full. Please bring it with you to your dental visit.

I have highlighted some important pieces of information.

Please make sure your last xrays are emailed to us. We need your FMS(full mouth series)PRIOR to your visit at:

office@kfdental.com

*If you are scheduled to see one of our specialists please make sure the referral is emailed as well.

REGISTRATION FORM

This personal information is requested to enable us to give you the most consideration of your time and feelings. It is important t complete answers so that we may give you the personal attention you deserve. This information is completely confidential. Thank y

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH _____ SEX _____M _____F S.S. NUMBER _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

Mailing address if different than above: _____

EMAIL ADDRESS: _____

EMPLOYER _____ WORK PHONE _____

IF MARRIED, WHAT IS YOUR SPOUSE'S NAME? _____

SPOUSE'S DATE OF BIRTH _____ SPOUSE'S S.S. NUMBER _____

SPOUSE'S EMPLOYER _____ SPOUSE'S WORK NUMBER _____

ARE YOU EXPERIENCING ANY DENTAL PROBLEMS AT THIS TIME? IF SO, WHAT? _____

_____

HOW LONG HAS IT BEEN SINCE YOU HAVE SEEN A DENTIST? _____

WHAT WAS DONE THEN? _____

HOW DID YOU HEAR ABOUT US? _____

DO YOU HAVE DENTAL INSURANCE? _____

In order to obtain maximum dental benefits for our insured patients, we have our staff specifically trained to do just that. In orde get your full complete benefits, we will need the following:

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

GROUP #: _____ SUBSCRIBER #: _____ PHONE #: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY # OF SUBSCRIBER: _____

I HEREBY AUTHORIZE AND REQUEST THE PERFORMANCE OF DENTAL SERVICES FOR MYSELF BY THE ST OF NANARAO KROTHAPALLI, DMD, LLC.

I ALSO GIVE MY CONSENT TO ANY ADVISABLE AND NECESSARY DENTAL PROCEDURES, MEDICATIONS, O ANESTHETICS TO BE ADMINISTERED BY OUR STAFF FOR DIAGNOSTIC PURPOSES OR DENTAL TREATMENT.

I UNDERSTAND AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES RENDEI REGARDLESS OF INSURANCE COVERAGE.

_____ _____

(SIGNATURE) (DATE)

Dr Nanarao Krothapalli

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

NANARAO KROTHAPALLI, D.M.D.
25 Nashua Road, Unit D3 • Londonderry, NH 03053 | Phone: (603) 432-6480 • Fax: (603) 432-9232

Appointment Cancellation Policy

At our office, appointments are made in advance by reserving the appropriate time slots to accommodate you, the patient, and your treatment to be performed. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing, and arranging the set up items prior to your arrival. This ensures that we achieve the high standard of care and treatment that we pride ourselves on. We, therefore, require at least 2 business days notice prior to cancelling or rescheduling appointments. Patients who cancel or reschedule their appointment without proper notice will be assessed a $10.00 fee for every 10 minutes of appointment time to offset the lost production time and estimated amount of time and effort the staff has already spent preparing for the appointment.

**** PLEASE NOTE *** as an extended courtesy to our patients we offer limited Saturday hours. Due to the nature of our Saturday availability we have a strict Saturday cancellation policy. Therefore, we must be notified by Tuesday, before 12:00 noon, of the same week with any changes you need to make to that appointment. The assessment above will apply to any Saturday appointment canceled or rescheduled after that time frame. This stricter policy is to accommodate patients on a waiting list for a Saturday appointment.

We look forward to accomplishing all of your treatment needs in a comfortable and caring environment. Please contact our office at (603) 432-6430 if you have any questions or concerns.

Patient Name: _____

Patient/Responsibility Party Signature:

_____

Date: _____

DENTAL TREATMENT CONSENT FORM
COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "coronavirus," at any time or in any place. Be assured that we continue to follow state and federal regulations as well as recommended universal personal protective equipment (PPE) and disinfection protocols to limit transmission of all diseases in our office.

Despite careful attention to sterilization, disinfection and the use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be exposed at your gym, grocery store or favorite restaurant. Nationwide social distancing has reduced the transmission of the coronavirus. Although we have taken measures to enable social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dental healthcare team members and sometimes other patients at all times. Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes _____ No _____

_____ _____

Patient/Parent's Signature + Print Date

****Please inform the office if you develop any Covid-19 symptoms within 14 days of your dental appointment****

Sign+Print

Nanarao Krothapalli, DMD, PLLC
Patient Consent for Treatment/Acknowledgement

I hereby authorize Dr. Krothapalli or his designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize the doctor to perform the recommended treatment agreed by me and to employ such assistance as required to provide proper care.

I agree to the use of local anesthesia, sedatives, and other medication as necessary. I fully understand that I can ask for a complete recital of any possible complications.

In the event payment is not received by agreed upon date determined by our office, your account will be turned over to our collection agency and you will be charged an additional 25% of the balance due for collection.

By signing below, you consent to the use and disclosure of your protected health information by Nanarao Krothapalli, DMD, PLLC to our staff and our business associates for treatment, payment and health care operations. For a more detailed description of the uses and disclosures for these purposes, please review our notice prior to the consent. The terms of this notice may change. If they do change, you may obtain a revised notice by contacting our office at (603) 432-6430. You have a right to request that we restrict our uses or disclosures of your protected health information, which we otherwise permitted to make for treatment, payment and healthcare operations although we are not required to agree to further restrictions they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law we have the right to refuse to treat you should you choose to refuse to disclose your protected health information (PHI).

This form is to also obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

Patient's Name _____ **Date** _____

Patient/Responsible party signature_____
Relationship:_____

Please specify the exact reason if the patient chose not to sign the consent or acknowledgement of Notice of Privacy.

_____
_____
_____