Patient Name: _____ DOB: _____
Last, First MI (Preferred Name)

## Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

**Have you ever had any of the following? Please check those that apply:**

- ☐ AIDS/HIV
- ALLERGIES:
  - ☐ Codeine
  - ☐ Penicillin
  - ☐ Latex
  - ☐ Sulfa
  - ☐ Seasonal (Hay Fever)
- ☐ Anemia
- ☐ Arthritis
- ARTIFICIAL JOINTS:
  - ☐ Hip
  - ☐ Knee
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Head Injuries
- ☐ Heart Problems
- ☐ HPV
- ☐ Hepatitis A,B or C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ MRSA
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- OTHER:
  - ☐ _____

- Please list all **medications you are currently taking & for what purpose:**

_____

_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

  If yes, please explain: _____

- Do you have a primary physician? ☐ Yes ☐ No Name of physician: _____ Phone: _____

  If yes, please explain: _____

- Do you use tobacco products? (Smoke or Chew) ☐ Yes ☐ No

- Do you snore? ☐ Yes ☐ No

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

**For Completion by Dr. Chenet:**

**Comments on patient interview on medical history:**

_____

**Significant findings from questionnaire and oral interview:**

_____

**Dental Management Considerations:**

_____

_____
**Date** **Dr Chenet**

## Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____ DL# _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell# _____

Preferred Number to reach you: _____

Address: _____
Street Apartment #

_____
City State Zip

E-Mail Address: _____

Referred By: _____

## Parent or Legal Guardian Information (if applicable)

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Emergency Contact

Emergency Contact: _____ Phone Number: _____

## Insurance Information (if applicable)

**Primary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

**Secondary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

**Name**_____

## Consent for use and Disclosure of Health Information

### PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

**Purpose of this content:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health operations. **WE WILL NOT RELEASE ANY OF YOUR HEALTH INFORMATION TO MARKETORS OR SOLICITORS.**
The undersigned hereby authorizes Dr. Chenet and/or his staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with my treatment and further authorize and consent that Dr. Chenet and his staff choose and employ such assistance as deemed fit and suitable. I also understand that the use of anesthetic agents embodies a certain risk.
**Notice of Privacy Practices:** You have a right to read our Notice of Privacy Practices before you decide whether or not to sign this consent. Our Notice (NOPP) provides a description of our treatment, payment activities and health care operations, of uses and disclosures we may make with your protected health information and of other important matters about your protected health information. A copy of our NOPP accompanies this consent upon request. We encourage you to read it carefully before signing this consent.

We reserve the right to change practices at any time as described in our NOPP. You may obtain a copy of our NOPP, including any revisions, at any time by contacting our Privacy Officer at our office.

**Right to Revoke:** You will have the right to revoke this consent at any time by completing and submitting a Revocation of Consent form to our Privacy Officer.

I, _____ have had a full opportunity to read and consider the contents of this consent form and your NOPP. I understand that by signing this form, I am giving my permission to use and disclose my protected health information to carry out treatment, payment and health care operations. I also understand that you may decline to treat me if I refuse to sign this Consent.

_____ _____
Signature of Patient, Parent, Guardian or Representative Date

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. Our practice depends upon reimbursement from our patients for the costs incurred for their care and financial responsibility on the part of each patient must be determined prior to treatment.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at the time of service.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment. This office will help prepare the patient's insurance forms or assist in making collections from insurance and will credit any such collections to the appropriate account. However, this dental office cannot render treatment on the assumption that our charges will be paid by the insurance company.

I understand that the fee estimated for my dental care can only be extended for a period of sixty (60) days from the original estimated date.

In consideration for the professional services rendered to me, or at my request, by Dr. Chenet and/or his staff, I agree to pay therefore the reasonable value of said service to Dr. Chenet, or his assignee, at the time said service is rendered or within five (5) days of billing if credit has been extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee to telephone me at home or work to discuss matters related to this form.I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____
Signature of Patient, Parent or Guardian Date Relation to Patient

_____ _____ _____
Signature of Guarantor of Payment/Responsible Party Date Relation to Patient

Cedric C Chenet DDS, PA

# Dental History Questionnaire

Name:_____

Why have you come to the dentist today?_____

Date of your last dental visit_____Cleaning_____X-Rays_____

How often do you brush?_____Floss?_____Other cleaning aids?_____

Are your teeth sensitive to Heat_____Cold_____Sweets_____Other_____

Do you have pain or discomfort with any teeth?_____If yes, where?_____

Do your gums bleed?_____w/brushing?_____w/flossing?_____

Have you been diagnosed with Periodontal Disease?_____If yes, when?_____

Have you had Periodontal treatment?_____If yes, when?_____

Have you had Orthodontics?_____If yes,when?_____

Oral Surgery?_____When_____Bite Adjusted?_____When_____

Have you replaced any missing teeth?_____If yes,when?_____

Are any of your teeth crowned?_____If yes,when?_____

Are you satisfied with your teeth's appearance and color?_____If no, what would you change?_____

Have you ever had any complications following dental treatment?_____ If yes, please explain_____

Please list your chief Dental Complaint(s):_____

_____

_____ _____

Signature of patient, parent or guardian Date

**Cedric C. Chenet, DDS, PA**
**General and Cosmetic Dentistry**
7331 Office Park Place, Suite 100
Melbourne, Fl 32940
(321) 253-3136

# HIPAA

## CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize **Cedric C. Chenet DDS, PA** (hereafter collectively referred to as "Practice") to use and disclose the entire dental record concerning my treatment in accordance with the Notice of Privacy Practices (NOPP) to:

1._____.

2. _____.

I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Cedric C. Chenet, DDS, PA to use and disclose verbally, by mail, fax or unencrypted e-mail, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

Patient Signature:_____ Date:_____

Or

Patient's Representative Signature (and relationship):

Date:_____

_____

**Cedric C. Chenet, DDS, PA**
**General and Cosmetic Dentistry**
7331 Office Park Place, Suite 100
Melbourne, Fl 32940
(321) 253-3136

# REQUEST FOR DENTAL RECORDS RELEASE

To: _____
_____
_____
_____

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____
_____
_____
_____

**Please send copies of all of my dental records, x-rays, medication sheets, interpretations of tests, periodontal chartings and progress notes pertaining to my dental treatment (including information from other health-care providers) to:**

Cedric C. Chenet, D.D.S., P.A.
7331 Office Park Place, Suite 100
Melbourne, FL 32940
Telephone Number: 321-253-3136
Fax # : 321-253-6411

**Email: frontdesk@chenetdental.com**

_____ Date: _____
Patient's Signature

or

_____ Date: _____
Signature of Responsible Party if Patient is a Minor