

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: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____
Address: _____
Street City State Zip Code Phone

Insurance Information

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: _____

Patient Name: _____ Age: _____ Date: _____
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:

- | | | | |
|--------------------------------------------|----------------------------------------------|-----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> MRSA |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

• 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: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• 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.

Signature of patient, parent or guardian _____ Date: _____

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

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 you teeth's appearance? _____ 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

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