



Cedric C. Chenet, DDS, PA

General and Cosmetic Dentistry

7331 Office Park Place, Suite 100

Melbourne, FL 32940

(321) 253-3136

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care at reasonable cost, and proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

Your appointment will take approximately 2 hour. To facilitate being seen just as soon as possible at the time of your appointment, we would appreciate it if you would complete the enclosed Patient Information Form before your arrival. Please remember to bring it with you at the time of your appointment or mail the completed form back to us as soon as possible.

If you are unable to make the appointment you have scheduled with us, please notify us at least 24 hours in advance. We would be glad to reschedule the appointment at a more convenient time, if necessary. In the meantime, we look forward to meeting you and serving your needs.

Thanks again for choosing our dental practice.

Sincerely,

Cedric C. Chenet, DDS, PA

P.S. Remember to bring any Insurance cards that might apply to you or your family when you come. We can then include this information with your records.



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From Melbourne:

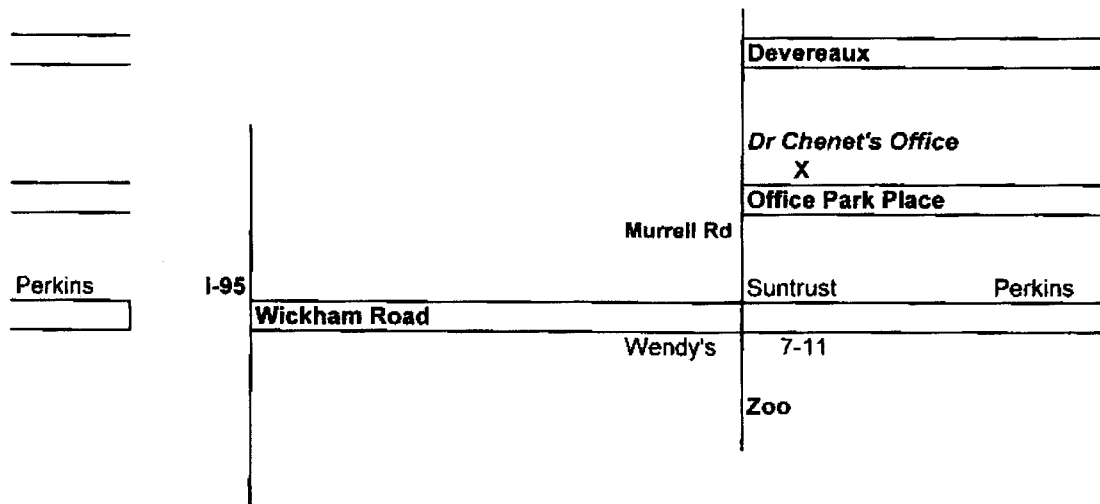
North on Wickham Road
Turn **Right on Murrell Road** (Zoo is on the Left)
Immediate **Right into our Parking Lot**
First One Story Yellow Building on the Left - Suite 100 -

From I-95

I-95 Northbound
Exit 191 Wickham Road
Turn **Right on Wickham Road**
Turn **Left on Murrell** (double turn lane - stay on right hand turn lane)
Immediate **Right into our Parking Lot**
First One Story Yellow Building on the Left - Suite 100

I-95 Southbound
Exit 191 Wickham Road
Turn **Left on Wickham Road**
Turn **Left on Murrell** (double turn lane - stay on right hand turn lane)
Immediate **Right into our Parking Lot**
First One Story Yellow Building on the Left - Suite 100

We look forward to seeing you! Please call if you need further instructions!



Make immediate right. Go to opposite end of yellow one story building - Suite 100

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

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

• 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.

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

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

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: _____

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



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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: E-mail address is

Frontdesk@chenetdental.com

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

Patient's Signature Date: _____

or

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

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**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):

By Patient: _____
(Print name and sign)

Date: _____

Or

By Patient's Representative _____
(Print name, sign, and describe authority below)

Date: _____