DeLand Implant Dentistry

Dr. Jayraj Patel, DMD

150 McGregor Road, Deland, FL 32720/Tel. 386.738.2006 / Fax 386.738.2007/ www.delandimplants.com

PATIENT INFORMATION [Confidential]

Name: _____ Date of Birth : _____/_____/_____

Address :_____ City :_____ State: _____ Zip: _____

Driver License:_____ Home Phone: (___) ____ - _____ Cell (_____) _____-_____

E-mail : _____

Check appropriate line: Minor___ Single ____ Married ____ Divorced ____ Widowed ____ Separated ____

If college student, FT / PT, Name of School :_____ City _____State ____

Patient's or Parent's employer: _____ Work Phone: (____)_____-_____

Business Address: _____City _____ State: ____ Zip: _____

Spouse Name or Parent's Name: _____ Employer: _____ Work Phone: (___) ____ - _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: (____) ____ - _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account: _____

Relationship To Patient: _____

Address: _____ Phone: (___)_____

Driver's License # _____ DOB: ___/___/____ S.S. Number: _____

INSURANCE INFORMATION

Name of Person Responsible for this Account: _____

Relationship To Patient: _____DOB: ____/____/_____

Name of Employer: _____ Date Employed: _____

Work Phone: (____) _____ - _____

Employer Address: _____ City _____ State: _____Zip: _____

Insurance Company:_____ Phone: (____)____-_____ Group #_____ Policy/ID #: _____

Ins. Co. Address: _____ City _____ State: ____ Zip: _____

How much is your Deductible? _____ How much have you used? _____ Max annual Benefit? _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that I am required to pay in full for the treatment and services provided by Dr. Patel and/or his staff at the time of services and get reimbursed from my insurance company. I hereby authorize Dr. Patel to release any information necessary to secure the payment of benefits. I authorize use of this signature for all insurance submissions.

_____ _____ _____

Signature of Patient/guardian or Parent if Minor | Relationship to patient | Date

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Patient Preferences

Patient: _____ Date:_____

Briefly tell us how you feel about your teeth, your smile, and your dental expectations.

1. What are your expectations from this office? _____
_____

2. Would you like to learn how you can have all of your teeth for the rest of your life? ___Yes ___No

3. If you are already missing some teeth, would you like to learn how you can avoid having full dentures? ___Yes ___No

4. Do you like your smile? ___Yes ___No

5. If the answer is NO, what don't you like and what changes would you like to see? _____
_____
_____

6. If you feel that your teeth have yellowed, or are not white enough, would you like to learn about tooth whitening? ___Yes ___No

7. Are you interested in an overall cosmetic dental evaluation? ___Yes ___No

8. If you are contemplating a dental cosmetic change, what is most important to you? _____
_____
_____

9. Are you aware of anything that might prevent you from having either basic or cosmetic dental treatment? ___Yes ___No

10. Have all your past dental office experiences been positive? ___Yes ___No
if NO, please explain: _____
_____

11. Is there anything in particular that you would like us to always do for you? ___Yes ___No
if YES, please explain: _____
_____

12. Is there anything in particular that you would like us never to do? ___Yes ___No
if YES, please explain: -
_____

13. Do you have any dental concerns not listed here that you would like to bring to our attention? ___Yes ___No
if Yes, please explain: _____
_____

14. If our office needs to contact you, you prefer: Mail _____ Telephone _____ Text _____ Email _____
My email address is: _____

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PATIENT HEALTH QUESTIONNAIRE

Patient's Name: _____ **Date of Birth:** _____

1. What is your major concern about your mouth or teeth?
   _____
2. Describe your oral / dental health:
   _____
3. Date of last dental exam: _____
4. Describe your general health: _____
5. Date of last physical exam: _____
6. Has there been **any change in your general health in the past year?** ___ Yes ___No
   If yes, what condition? _____
   _____
7. Are you **presently** under a physicians care? ___ Yes ___No
   If yes, please explain: _____
   _____
8. Have you been **hospitalized** within the past 5 years? ___ Yes ___No
   If yes, explain: _____
   _____
9. Your physician's name and address: _____
   _____
   Telephone: (_____) – _____ - _____
10. List all medications you are taking (or supposed to take) including over the counter medications, Aspirin, birth control pills or hormones (if none, so state):

Medication	-	**Dosage**	-	**Time / Day**

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Patient Name: _____ **Date of Birth:** _____

Medical History

Please indicate the appropriate answer if you have / had any of the following

Heart / Cardiovascular

1. ___ Yes ___No: Rheumatic Heart Disease / heart murmur
2. ___ Yes ___No: Damaged or Artificial heart valve
3. ___ Yes ___No: Mitral valve prolapse
4. ___ Yes ___No: Congenital heart disease
5. ___ Yes ___No: High blood pressure
6. ___ Yes ___No: Low blood pressure
7. ___ Yes ___No: Arteriosclerosis / High cholesterol
8. ___ Yes ___No: Chest pain after exertion
9. ___ Yes ___No: Shortness of breath after mild exercise
10. ___ Yes ___No: Heart attack
11. ___ Yes ___No: bypass surgery
12. ___ Yes ___No: Heart pace maker/Irregular or rapid Heart rate
13. ___ Yes ___No: Stroke
14. ___ Yes ___No: Do your ankles swell?
15. ___ Yes ___No: Do you use extra pillows to sleep?
16. ___ Yes ___No: Other heart problems?

Allergies To:

1. ___ Yes ___No: Penicillin
2. ___ Yes ___No: Sulfa
3. ___ Yes ___No: Aspirin / Codeine / Other pain medications _____
4. ___ Yes ___No: Iodine
5. ___ Yes ___No: Sedatives / Sleeping Pills / Barbiturates
6. ___ Yes ___No: Local Anesthetics

   _____
7. ___ Yes ___No: Latex
8. ___ Yes ___No: Metals

   _____
9. Other Medications: -

   _____

   _____

Breathing / Lungs / Sinuses

1. ___ Yes ___No: Shortness of breath / Breathing problem
2. ___ Yes ___No: Asthma / Hay fever
3. ___ Yes ___No: Emphysema / COPD
4. ___ Yes ___No: Tuberculosis / Persistent cough or cold
5. ___ Yes ___No: Sinus problem / Sinusitis /Nasal problem
6. ___ Yes ___No: Do you smoke?

Central Nervous System

1. ___ Yes ___No: Epilepsy
2. ___ Yes ___No: Fainting Spell
3. ___ Yes ___No: Seizures
4. ___ Yes ___No: Emotional disturbances

Blood Conditions

1. ___ Yes ___No: Anemia
2. ___ Yes ___No: Leukemia
3. ___ Yes ___No: Sickle Cell trait / Disease
4. ___ Yes ___No: Hemophilia/Excessive bleeding/Bruise easily
5. ___ Yes ___No: Blood transfusion
6. ___ Yes ___No: HIV positive
7. ___ Yes ___No: Family history of blood disorder

Endocrine System

1. ___ Yes ___No: Do you have Diabetes?
2. ___ Yes ___No: Does anyone in your family have Diabetes?
3. ___ Yes ___No: Hypothyroidism / Hyperthyroidism
4. ___ Yes ___No: Are you thirsty very often / Have a dry mouth?

Digestive System

1. ___ Yes ___No: Stomach ulcers
2. ___ Yes ___No: Hepatitis
3. ___ Yes ___No: Jaundice
4. ___ Yes ___No: Liver Disease

Bones and Joints

1. ___ Yes ___No: Arthritis
2. ___ Yes ___No: Inflammatory Rheumatism
3. ___ Yes ___No: Bone infection
4. ___ Yes ___No: Artificial joints
5. ___ Yes ___No: Osteoporosis

Other

1. ___ Yes ___No: Kidney trouble
2. ___ Yes ___No: Dialysis
3. ___ Yes ___No: Syphilis / Gonorrhea
4. ___ Yes ___No: Lupus / Auto Immune Disease
5. ___ Yes ___No: Do you have glaucoma?
   If yes, what type: Narrow angle:_____ Open angle:_____

Neoplasm

1. ___ Yes ___No: Cancer / Tumor
   If yes, what kind?

   _____
2. ___ Yes ___No: Chemotherapy
   If yes, what medications?

   _____
3. ___ Yes ___No: Radiation Therapy
   If yes, area of radiation: _____

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Medical History (cont.)

General

1. ___ Yes ___No: Do you have or have you ever had any condition, disease, or problem NOT listed above that you think I should know about?
   If yes, explain:
   _____
2. ___ Yes ___No: Do you Drink Alcohol?
   If yes, how much and how often?
   _____
3. ___ Yes ___No: Do you smoke?
   If yes, how much?
   _____
4. ___ Yes ___No: Do you use oral tobacco?
   If yes, how much and how often?
   _____
5. ___ Yes ___No: Do you use any recreational drugs?
   If yes, what and how often?
   _____

Women Only

1. ___ Yes ___No: Are you pregnant or suspect being pregnant?
2. ___ Yes ___No: Are you nursing?
3. ___ Yes ___No: Are you taking any oral contraception or hormonal therapy?
4. ___ Yes ___No: Osteoporosis

Man only:

1. ___ Yes ___ No: Do you use any medication for Eractile Dysfunction?
   If yes, what and when was the last time you used it?
   _____

Dentist's Notes

VITAL SIGNS

B.P.:_____ H.R. : _____ Resp Rate : _____

Weight: _____ Temp :_____

AUTHORIZATION

I understand that the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all the questions to the best of my knowledge. I will not hold Dr. Patel or any other member of his staff responsible for any error or omissions that I might have made in the completion of these forms. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify Dr. Patel of any change in my health or medications. I also consent to the performing of oral and dental exams including any radiographs and any dental treatment and procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated. I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions such as redness and swelling of tissue, pain, itching, vomiting and/or anaphylactic shock.

_____ _____

Patient's/Guardian's Signature **Date**

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Patient Name: _____ **Date of Birth:** _____

Dental History

1. What is your chief dental complaint? _____
2. Are you experiencing any discomfort or pain? ___ Yes ___No
3. How often do you have your dental exam? _____
4. When was your last dental visit? _____
5. Do you feel nervous about dental treatment? ___ Yes ___No
6. Have you had any serious trouble associated with any previous dental treatment? __Yes __No
7. Are you satisfied with the appearance of your teeth? ___ Yes ___ No
   If NO what would you like to have changed about the way your teeth looks? _____
   _____
8. Are your teeth sensitive to hot or cold? ___ Yes ___No
9. Do your gums bleed when you brush? ___ Yes ___No
10. Have you noticed any bad odor or bad taste? ___ Yes ___No
11. Do you get frequent cold sores, blisters etc.? ___ Yes ___No
12. Do you clinch or grind your teeth while awake or asleep? ___ Yes ___No
13. Do you have tired jaw, especially mornings? ___ Yes ___No
14. Are you aware of jaw joint sound? ___Yes ___No
15. Did you ever have jaw joint sound? ___Yes ___No
16. Do you ever have pain or soreness in front of your ears? ___Yes ___No
17. Do you have ear pain? ___Yes ___No
18. Do you wake up with your jaws sore or tired? ___Yes ___No
19. Do you ever have difficulty opening your jaw widely? ___Yes ___No
20. Do you avoid eating certain foods because of pain or discomfort? ___Yes ___No
21. Do you snore? ___Yes ___No
22. Has anyone reported that you choke or gasp for air while sleeping? ___Yes ___No
23. Do you wake up refreshed? ___Yes ___No

Have you had or experienced:

1. __ Yes __ No : Orthodontic treatment
2. __ Yes __ No : Bite adjustment
3. __ Yes __ No : Oral surgery
4. __ Yes __ No : Bite plate/mouth guard
5. __ Yes __ No : Periodontal Treatment
6. __ Yes __ No : Injury to head/mouth
7. __ Yes __ No : Clicking/popping of jaw
8. __ Yes __ No : Difficulty chewing
9. __ Yes __ No : Difficulty opening or closing
10. __ Yes __ No : Sore mouth/neck/shoulder

Do you wear dentures now? ___ Yes ___ No

__Upper complete __Lower Complete __Upper Partial __Lower Partial

Since how long?_____

How old is this denture? Upper_____ Lower_____

Was it an immediate denture? ____ Yes ____No

Do you like the **shape**? ___ Yes ___No **Size**? ___Yes ___No **Color**? ___Yes ___No

Other Comments:_____

What's most important to you in your dental health? _____

_____

What is most important to you when choosing a dentist? _____

_____

_____ _____

Patient's/Guardian's Signature **Date**

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OFFICE FINANCIAL POLICY

Financial Arrangements:

Once it is determined exactly what treatment procedures are needed and how much those procedures will cost, payment options can be discussed. Our primary concern is your oral/dental health. Nonetheless, we will be sensitive to your financial circumstances within the framework of sound business and the standard practice of dentistry. We will make every effort to provide you with a treatment plan which fits your timetable, budget, and gives you the best dental care.

We are **Fee for Service** practice. Fees for professional services are due at the time treatment is provided. Payment must be made by cash, check, debit or credit card. We accept Visa, MasterCard, Discover and Care Credit cards. Financial arrangements (Payment Plans) can be made at our office through ***Care Credit***, which can offer 6 or 12 months no interest payment options. Please inquire about Care Credit by calling our office or visiting their website carecredit.com. **For appointments that require a 2 hour block of time or longer, we will require a 50% deposit at least one week prior to the appointment date in order to secure the appointment.**

Surgery Payments are due at Pre-Op Appointment.

Dental Insurance:

Our treatment recommendations are always based on your needs and desires, not on what your insurance company would cover or its bottom line. Payments for all dental treatments will be due at the time when services are rendered. Any benefit due to you will come directly to you from your insurance carrier. We can make no guarantee of any estimated coverage, but we'll do our best to see that you receive your maximum benefits.

A Fee of $75.00 per hour will be charged for patients who miss or cancel their appointment without a 48 hour notice. Cancellations are not accepted on the answering machine.

Most patients find that the benefits of a healthy, beautiful smile far outweigh the associated costs.

I understand and agree to the office financial policy.

_____ _____

Patient's/Guardian's Signature **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **DeLand Implant Dentistry,** this _____ day of _____, 20___. A copy of this signed, dated Acknowledgement shall be effective as the original.

_____

PLEASE PRINT YOUR NAME PLEASE SIGN YOUR NAME DATE

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority:

_____.

Thank you and if you have any questions about this form or the attached notice, please contact our privacy officer.

Office Use Only As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledge but did not because:

- ☐ It was emergency treatment.
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because:_____.
- ☐ Other (please describe) _____.

Signature of Privacy Officer_____.

==========

AUTHORIZATION TO DISCUSS HEALTHCARE ISSUES

_____ _____

Patient Name Date of Birth

I hereby authorize **Dr. Patel** and/or his other staff members to discuss my healthcare issues with the following person(s):

Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____

I understand I have the right to: - Receive a copy of this authorization
- Revoke this authorization

This authorization will remain in effect until the following date: _____ or until otherwise notified (initial here): _____

_____

Signature of Patient/Legal Representative Relationship to patient Date