

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

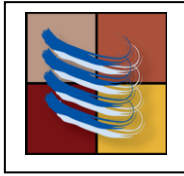
Name of Person Responsible for this Account: _____
 Relationship To Patient: _____ DOB: ____/____/____
 Name of Employer: _____ Date Employed: _____
 Work Phone: (____) ____ - _____
 Employer Address: _____ City _____ State: ____ Zip: _____
 Insurance Company: _____ Phone: (____) ____ - _____ Group # _____ 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? _____

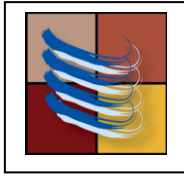
9. Are you aware of anything that might prevent you from having either basic or cosmetic dental treatment? ___Yes ___No
10. Have all your past dental office experiences been positive? ___Yes ___No
if NO, please explain: _____

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

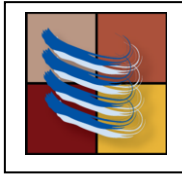
If yes, explain: _____

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

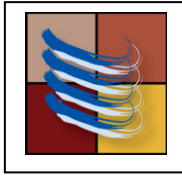
If yes, what kind?

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

- 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:

- Yes No: Do you Drink Alcohol?
If yes, how much and how often?

- Yes No: Do you smoke?
If yes, how much?

- Yes No: Do you use oral tobacco?
If yes, how much and how often?

- Yes No: Do you use any recreational drugs?
If yes, what and how often?

Women Only

- Yes No: Are you pregnant or suspect being pregnant?
- Yes No: Are you nursing?
- Yes No: Are you taking any oral contraception or hormonal therapy?
- Yes No: Osteoporosis

Man only:

- Yes No: Do you use any medication for Erectile Dysfunction?
If yes, what and when was the last time you used it?

Dentist's Notes

VITAL SIGNS

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

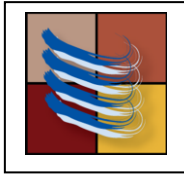
Weight: _____ Temp : _____

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 clench 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

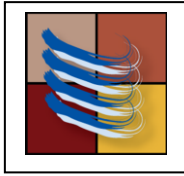
Other Comments: _____

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.

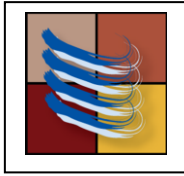
A Fee of \$75.00 per hour will be charged for patients who miss or cancel their appointment without a 48 hour notice. Cancellations are not accepted on the answering machine.

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: _____
 Name: _____
 Name: _____
 Name: _____

Relationship: _____
 Relationship: _____
 Relationship: _____
 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