PATEL DENTAL PLLC

Sandeep V. Patel, DDS, FAGD & Darshan P. Patel, DMD

201 W. International Speedway Blvd

Daytona Beach, FL 32114

Date _____

Name: _____ SWMD _____

Residence: _____

_____

City State Zip

Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: ____/____/____ Social Security Number: _____

Occupation: _____

Employer: _____

Address: _____

Phone: (____) _____

Referred By: EMAIL

Insurance Information

Do you have Dental Insurance? ❑ Yes ❑ No

Primary Policy Holder: _____

S.S. #: _____ Date of Birth of Policy Holder____/____/____

Employer: _____

Employer Phone: (____) _____

Insurance Company: _____

Address: _____

Telephone: (____) _____ Group Number: _____

Method of Payment: ❑ Cash ❑ Check ❑ Credit Card

Person Responsible for Payment of Account: _____

Name of Physician : _____

Address: _____

Phone: (____) _____

Approximate date of last physical examination: _____

Person to notify in case of emergency: _____

Address: _____

Phone: (____) _____

Signature: _____

Thank you for your cooperation.

-Additional Comments-

The following information about your dental and medical history is important in helping us provide the best care and treatment for you.

DENTAL HEALTH HISTORY

	YES	NO
1. Do you have a specific problem that needs attention now?	☐	☐
Explain: _____		
2. What prompted you to seek dental care at this time? _____		
3. Are you satisfied with your past dental care?	☐	☐
4. Do you have any fear of having dental treatment?	☐	☐
5. How long since your last dental exam? _____		
6. Are your teeth sensitive to hot, cold, sweets or pressure?	☐	☐
7. Are you pleased with the appearance of your teeth?	☐	☐
If not, why? _____		
8. Do you frequently eat sweets? _____ mints? _____ chew gum? _____		
9. Do your gums ever bleed when you brush your teeth?	☐	☐
10. Are you troubled with bad breath or bad taste?	☐	☐
11. Have you noticed loose, shifted, tilted or separating teeth?	☐	☐
12. Are your gums swollen, red or tender?	☐	☐
13. Have you ever had your gums treated?	☐	☐
Explain: _____		
14. Are you aware of grinding or clenching your teeth?	☐	☐
15. Do you hear noises near your ear when opening/closing your mouth?	☐	☐
Explain: _____		
16. Have you had any limitation of jaw movement?	☐	☐
17. Do you have jaw pains or headaches often?	☐	☐
18. Have you lost teeth other than wisdom teeth?	☐	☐
Have they been replaced?	☐	☐
19. Do you have any crooked/crowded teeth that bother you?	☐	☐
20. Do you have spaces between your teeth?	☐	☐
21. Have you had local anesthesia for most treatments?	☐	☐
22. Have you had any orthodontic treatment (braces)?	☐	☐
When? _____		
23. Would you like to have your natural teeth the rest of your life?	☐	☐
24. Have you had any serious trouble associated with dental treatment?		
Explain: _____		

MEDICAL HEALTH HISTORY

	YES	NO
25. Do you have any health problems?	☐	☐
If so, specify: _____		
26. Are you currently under a physician's care?	☐	☐
Reason: _____		
27. Have you been hospitalized within the past two years?	☐	☐
Reason: _____		
28. Have you had any implants of any kind (knee, hip, etc.)?	☐	☐
Explain: _____		
29. Have you ever been given corisone or steroids in the past year?	☐	☐
Explain: _____		
30. Have you ever had chemotherapy?	☐	☐
Explain: _____		
32. Have you ever had radiation therapy, cobalt or radium teatment?	☐	☐
Explain: _____		
32. Are you currently taking any prescription drugs?	☐	☐
List: _____		
33. Are you currently taking any over the counter medications (herbal/other)?	☐	☐
List: _____		
34. Are you currently taking aspirin or blood thinners?	☐	☐
35. Are you ALLERGIC to any medications?	☐	☐
List: _____		
36. Are you pregnant? _____ Month of pregnancy _____		
37. Do you have a dependency to alcohol or drugs?	☐	☐
38. Do you use tobacco?	☐	☐

39. To the best of your knowledge have you had or do you now have:

	Y	N		Y	N
Heart Ailment?	___	___	Repiratory Problems?	___	___
Diabetes?	___	___	Fainting Spells?	___	___
Rheumatic Fever?	___	___	Prolonged Bleeding?	___	___
Ear Problems?	___	___	Healing Complications?	___	___
Epilepsy?	___	___	Liver/Kidney Problems?	___	___
High Blood Pressure?	___	___	Nervous/Mental Problems?	___	___
Heart Murmur?	___	___	Joint Implants?	___	___
HIV?	___	___	Tuberculosis?	___	___
Hepatitus?	___	___	Heart Valve Replacement?	___	___

Office Financial Policy

We realize that every person's financial situation is different. For this reason, we have worked very hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile.

DENTAL INSURANCE

As a courtesy to you we are happy to file forms necessary to see that you receive the full benefits of your coverage, however, we do require full payment at the time of service. Our office fees are based on care, skill and judgment of the professionals delivering the services, and by the cost of operating a dental office dedicated to excellence. If there is a dispute over your insurance we will provide information to support the necessity for treatment, which may assist you in recovering your benefits.

PAYMENT OPTIONS

For your convenience, we accept Cash/Check/Debit/Visa/MC/Amex

Payment Plan: For patients who desire a monthly plan, we have made arrangements with Care Credit, there are no application fees or down payments and can be arranged interest free. Applications are available from our office or you can apply online at www.CareCredit.com.

It is our firm belief that all patients who come to our office and deserve the best dental care that can be provided. Dr. Patel's goal is to provide excellent service at a fair fee. Payment is due at the time professional services are provided.

Please sign below to indicate that you understand our policies and wish for us to proceed with treatment.

Signature_____ Date_____

HIPAA Notice of Privacy Practices
PATEL DENTAL PLLC

Sandeep V. Patel, DDS, FAGD & Darshan P. Patel, DMD

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

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To assess your personal feelings about your smile, fill in the following questionnaire. It will take just a few moments to answer the questions and provide a blueprint that will help us determine the type of treatments best suited to your unique situation.

1. Are you pleased with the general appearance of your teeth and smile? ___Yes ___No
   If no, please explain_____
2. Are your teeth straight? ___Yes ___No
   If no, please explain_____
3. Are there spaces between your front teeth that you dislike? ___Yes ___No
4. Are you satisfied with the color of your teeth? ___Yes ___No
   If no, please explain_____
5. Are you satisfied with the shape of your teeth? ___Yes ___No
   If no, please explain_____
6. Are any of your teeth chipped? Hidden? Protruding? ___Yes ___No
   If yes, please explain_____
7. Are you satisfied with the way your teeth come together (bite)? ___Yes ___No
   If no, please explain_____
8. Are your gums puffy, red or swollen looking? Do they bleed easily? ___Yes ___No
   If yes, please explain_____
9. Do you have old fillings or dental work that you think would look much better white? ___Yes ___No
10. Do you have any jagged teeth or teeth that you think are too long or too short? ___Yes ___No
11. Do you have missing teeth that make chewing difficult? ___Yes ___No
12. Do you frequently bite the inside of your cheek while chewing food? ___Yes ___No
13. What would you most like to change about the appearance of your teeth?
    _____
14. How would you like your teeth to look?
    _____

Please return your evaluation to us. We'd like to review your responses with you and together determine the best treatment options to create the beautiful and confident smile you envision and deserve. We may suggest one or several of the treatments summarized below.

Cosmetic Dental Treatment Choices

Cosmetic bonding involves applying a synthetic tooth-colored compound to your teeth to rebuild or cosmetically sculpt them into a desirable shape.

Crowns are permanent custom designed shells that cover the entire tooth to protect a weakened tooth or improve tooth appearance. Porcelain crowns are tinted to match the color of existing teeth.

Natural color fillings are tinted to match natural teeth and often are used to fill cavities on tooth surfaces or to replace old fillings.

A *permanent* bridge is a non-removable dental restoration that replaces a missing tooth.

Implants are used to replace a missing tooth by surgically positioning a metal post under the gum and attaching a custom crown to fill in the space.

Veneers are tooth-colored laminates or shells custom-fitted to cover the front surfaces of your natural teeth to provide better color, texture or shape.

Whitening or *bleaching* is a process that involves the application of a solution or gel to lighten teeth, giving them a brighter appearance.

You deserve the best the world has to offer, and a bright, beautiful smile is definitely within your reach. Please ask us any questions you have about these procedures, or about your general oral health and cosmetic options. We're here to help.