Port Orange Dentist

Implant, Family & Cosmetic Dentistry
Dr Harvinder S. Chadda B.D.S and Dr Amandeep S. Chadda D.M.D

The benefits of a happy healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Date: _____

Patient Information

Patient Name: Last _____ First _____ MI _____

Preferred Name: _____

____ Male ____ Female ____ Married ____ Single _____ Child ____ Other

SS #: _____ DOB: _____

Phone: (h) _____ (w) _____ (c) _____

E-Mail Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer Name: _____ Phone: _____

In Case of Emergency: Name _____ Phone: _____

Preferred Contact Method: Phone E-Mail Text

Responsible Party Information

*This information is for whomever is responsible financially for this patient and their treatment.

Name: Last _____ First _____ MI _____

____ Male ____ Female SS #: _____ DOB:_____

Phone: (h) _____ (w) _____ (c) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Referral Information

Whom may we thank for referring you to our practice?

Another Patient/Relative: _____ Dental Office: _____

Walk In _____ Other _____

PORT ORANGE DENTIST

Harvinder S. Chadda, B.D.S.
Amandeep Chadda, D.M.D

Patient Name: _____ DOB: _____

Primary Care Physician: _____ Phone: _____

Specialist Physicians: _____ Phone: _____

Pharmacy Name: _____ Location: _____

Any hospitalizations:

_____

_____

Any Surgeries:

_____

_____

Any changes in your phone number, mailing address, or email address:

_____

Do you have new or updated dental insurance? If yes, please provide the card and details to the front desk.

_____

HISTORY/CURRENT MEDICAL CONDITIONS (check **ALL** that apply)

- ☐ Heart Condition
- ☐ Chest Pain
- ☐ Heart Murmur/MVP
- ☐ Artificial Valve - Date: _____
- ☐ Rheumatic Fever
- ☐ Pacemaker - Date: _____
- ☐ Heart Stent
- ☐ Valve Replacement/ Repair

- ☐ Blood Conditions
- ☐ Easy Bruising
- ☐ Frequent Nose Bleeds
- ☐ Abnormal Bleeding
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Blood Transfusion

- ☐ Seasonal Allergies
- ☐ Emphysema

- ☐ Intestinal Problems
- ☐ Stomach Ulcers

- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Reflux
- ☐ Food Allergies

- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Weight loss surgery
- ☐ Gastric Bypass

- ☐ Bone/Joint Problems
- ☐ Osteoporosis
- ☐ Arthritis/ Rheumatism
- ☐ Neck/Back Pain
- ☐ Joint Replacement - Date: _____
  Which joint was replaced?_____
  Do you need to take antibiotics before seeing a dentist? Yes or No

- ☐ Fainting Spells/Seizures
- ☐ Stroke - Date: _____
- ☐ Aneurysm
- ☐ Headaches
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Spinal surgery

- ☐ Cancer - Type/Location: _____
- ☐ Radiation Treatment - Date: _____
- ☐ Chemo - Date: _____
- ☐ Infusion - Date: _____

- ☐ Diabetes - A1C: _____
  Type 1 or Type 2:_____
- ☐ Insulin pump
- ☐ Blood sugar monitor
- ☐ Prostate Problems

- ☐ Liver Disease
- ☐ Glaucoma
- ☐ Psychiatric/Nervous Disorder
- ☐ Smoker - How Often: _____
- ☐ Drug/Alcohol Abuse

- ☐ Hepatitis - Type: _____
- ☐ HIV/AIDS
- ☐ Herpes/STD
- ☐ Eating Disorder

WOMEN ONLY

- ☐ Birth Control
- ☐ Hormone Replacement
  Which hormone? _____
- ☐ Nursing

- ☐ Menopause
- ☐ Pregnant - Due Date: _____
  Current week:_____
  Trimester:_____

Any other condition or medical history not listed above:

_____

_____

Are you **allergic** to any of the following?

- ☐ None
- ☐ Local Anesthetic “Novocaine”
- ☐ Ibuprofen
- ☐ Penicillin
- ☐ Sulfa Drugs (Bactrim, Gantrisin, Septra)
- ☐ Barbiturates/Sedatives

- ☐ Aspirin
- ☐ Naproxen
- ☐ Codeine/Narcotics
- ☐ Metals - Type: _____
- ☐ Latex/Rubber Materials
- ☐ Other: _____

☐ Iodine

PAST OR CURRENT USE OF OSTEOPOROSIS/BONE MEDICATION

☐ Ostac
☐ Skelid
☐ Zometa
☐ Actonel
☐ Aredia
☐ Reclast
☐ Boniva
☐ Didronal
☐ Fosamax
☐ Other: _____

Are you on any of the following blood thinners?

☐ Warfarin
☐ Coumadin
☐ Plavix
☐ Xarelto
☐ Baby Aspirin
☐ Other:_____

Have you taken any antibiotics in the last 12 months?

☐ Amoxicillin
☐ Penicillin
☐ Clindamycin
☐ Azithromycin
☐ Other: _____
☐ If so, why:_____

Have you taken any of these medications in the last 12 months?

☐ Nitroglycerin
☐ Methadone
☐ Sulfa Drugs
☐ Pain Medication - List: _____
☐ Aspirin
☐ Cortisone (Steroids)
☐ Narcan
☐ Tranquilizers

If so, why: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

PORT ORANGE DENTIST

Harvinder S. Chadda, B.D.S.

Amandeep Chadda, D.M.D

Patient Name: _____

DOB: _____

Medication Reconciliation List

PLEASE PRINT CLEARLY

Drug	Dose	Frequency	Prescriber	Reason for Medication

Allergies: _____

_____

Patient Signature: _____ Date: _____

PORT ORANGE DENTIST

Harvinder S. Chadda, B.D.S.
Amandeep Chadda, D.M.D

Reason for dental visit today:

_____

_____

Dental History

Date of last dental exam: _____ Date of last x-rays: _____
Name of previous dentist: _____ Phone: _____

Does dental treatment make you nervous? Yes No
If so, would you say: Slightly Moderately or Extremely

Are your teeth sensitive to hot, cold, or chewing? Yes No

Are you experiencing any of the following?

Facial Swelling	Y	N	If so, how long? _____
Pain or discomfort	Y	N	If so, how long? _____
Red, swollen, or bleeding gums	Y	N	If so, how long? _____
Sensitive tooth, teeth, or gums	Y	N	If so, how long? _____

Do you have any blisters or sores in or around your mouth? Y N

Do you have any lost or broken fillings? Y N

Do you grind your teeth? Y N

Does your jaw click or pop while chewing or speaking? Y N

Do you open bottles with your teeth? Y N

Do you gag easily? Y N

Do you suffer from vertigo? Y N

Do you have back problems? Y N

Please let us know any additional information, so that we may better serve you today.

_____

_____

Patient Signature: _____ Date: _____

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Patient Financial Responsibility

Please initial #1 through #9 and sign at the bottom.

1. _____ **Payment is due the day service is rendered**. You are responsible for all charges for today and any future visits. If you have insurance we will assist you in filing your claim. We file your insurance as a courtesy to you, but you are responsible if they do not pay. Interest free financing is also available (upon credit approval). We do not accept personal checks.
2. _____ You are responsible to provide correct and accurate insurance information and advise us of any changes in insurance **PRIOR** to your visit. If you fail to provide us the information then you are responsible for all fees based on our UCR (usual and customary rate).
3. _____ You will be given a "Treatment Plan" for today and any future visits. If you have an insurance plan which we participate in that has a fee schedule the fees posted will be those of our regular fees. You are responsible for all charges if your plan denies payment, changes treatment codes, or does not pay within 45 days of your treatment date. If you do not have insurance or have a discount insurance plan the fees are your actual cost.
4. _____ Patients who are scheduled to have implants placed are required to prepay for all services pertaining to the implants.
5. _____ In some circumstances, procedures become more involved than originally anticipated. The patient is responsible for all additional charges. The office will advise you of these changes if necessary.
6. _____ If your account has a balance that is turned over for collections for further legal handling with an outside collection or attorney fees that will be added to your account.
7. _____ All crowns, bridges, dentures, partials, etc. must be paid in full before the finished product is delivered. If insurance is outstanding on any crown, bridges, dentures, partial, etc. the patient is responsible to pay the balance in full and will be reimbursed after your insurance company pays.
8. _____ **A 24 hour notice is required to be given when canceling an appointment. There will be a charge of $40 if the required notice is not given to cancel the appointment. It is required to give us a call back to confirm your appointment by voice or it might be necessary to reschedule or double-book your appointment.**
9. _____ A late fee of $30 (per month) will be charged to your account if balance is not paid in full within 15 days of the statement date, unless prior arrangements have been made with the Financial Coordinator. All financial arrangements, made with the Financial Coordinator, must be done in writing and a copy of the arrangement will be posted in the patient's chart and a copy wil be issued to the patient.

Patient's Printed Name (or legal guardian): _____

Patient's Signature (or legal guardian): _____

Date: _____ Relationship if other than patient: _____

Witness: _____ Date: _____

PORT ORANGE DENTIST
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HIPAA COMPLIANCE / PATIENT CONSENT FORM

Our notice of Privacy Practices provide information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by signature that you have reviewed our notice before signing this consent.

The term of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment., payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves that right to change the privacy policy as allowed by the law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send text to you to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

If yes, please name the members allowed:

_____

_____

This consent was signed by: _____

(Print name please)

Signature: _____ Date: _____

Witness: _____ Date: _____

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No-Show/Missed/Same Day Cancellation Appointment Office Policy

When we book your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule an appointment, please provide at least 24 hours' notice.

This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept. There is a charge of **$40.00 per hour** for not showing up for scheduled appointments.

*Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Every patient in our practice receives this unique reservation.

Patient name _____

Patient signature _____

Date _____