Waneta Chenault, D.D.S., P.A.

Patient Information

Patient Name: Mr. Mrs. Miss Dr. _____ Date: _____
Last First MI (Preferred Name)

Social Security #: _____ Driver's License #: _____ Birth Date: _____

Phone (Home):_____ (Work):_____ (Cellular): _____

Address: _____
Street Apartment #

_____
City State Zip Code Email

Referral Information (Whom may we thank for referring you to our practice?)

☐ Another patient ☐ Another Dental Office ☐ Internet ☐ Newspaper ☐ Mail ☐ Phone book**: Verizon** or **Area Wide**?

Why did you select our office? _____

Name of person or office referring you to our practice: _____

Health Information

Have you ever had any of the following? Please check "y" for "yes" or "n" for "no", and date when diagnosed:

y☐ n☐ AIDS or HIV
y☐ n☐ Angina Pectoris (chest pain)
Allergy to:
y☐ n☐ Codeine
y☐ n☐ Local Anesthetic
y☐ n☐ Aspirin
y☐ n☐ Penicillin
y☐ n☐ Nitrous Oxide (Laughing Gas)
y☐ n☐ Latex
y☐ n☐ Costume Jewelry / Other Metals
y☐ n☐ Other allergies:
_____
_____
y☐ n☐ Anemia
y☐ n☐ Anxiety
y☐ n☐ Arthritis / Rheumatism
y☐ n☐ Artificial Joints
y☐ n☐ Artificial Heart Valves
y☐ n☐ Asthma
y☐ n☐ Blood Disease
y☐ n☐ Bulimia

y☐ n☐ Cancer
y☐ n☐ Chemotherapy
y☐ n☐ Cold Sores / Fever Blisters
y☐ n☐ Depression
y☐ n☐ Diabetes or Blood Sugar Problems
y☐ n☐ Dizziness / Fainting
y☐ n☐ Epilepsy / Seizures
y☐ n☐ Excessive Bleeding
y☐ n☐ Emphysema or Lung Disease
y☐ n☐ Glaucoma
y☐ n☐ Growths
y☐ n☐ Hay Fever
y☐ n☐ Head Injuries
y☐ n☐ Heart Disease
y☐ n☐ Heart Surgery
y☐ n☐ Heart Attack / Failure
y☐ n☐ Heart Murmur
y☐ n☐ Hemophilia or other Blood Disorder

y☐ n☐ Hepatitis / Jaundice / Liver Disease
y☐ n☐ High Blood Pressure (hypertension)
y☐ n☐ High Cholesterol
y☐ n☐ Kidney Disease
y☐ n☐ Mental Disorders
y☐ n☐ Mitral Valve Prolapse
y☐ n☐ Nerve Disorders
y☐ n☐ Pacemaker
y☐ n☐ Phobias / Psychiatric Disorders
y☐ n☐ **Pregnancy**
Due date: _____
y☐ n☐ Radiation Treatment (What part of the body?)
_____
y☐ n☐ Respiratory Problems
y☐ n☐ Rheumatic Fever

y☐ n☐ Severe or Frequent Headaches
y☐ n☐ Stomach / Intestinal Problems
y☐ n☐ Stroke
y☐ n☐ Thyroid Disease
y☐ n☐ Tuberculosis (TB)
y☐ n☐ Tumors
y☐ n☐ Ulcers
y☐ n☐ Venereal Disease
y☐ n☐ Admitted to the hospital or needed emergency care in the past two years (please explain):
_____
_____
_____

☐ Other:
_____
_____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____

- Are you currently taking any medications or supplements? ☐ Yes ☐ No If yes, please list drug / supplement name and approximately how long you've been taking them: _____

_____

- Name of Physician:_____ Phone:_____

Dental Information

Date of last dental visit: _____ Reason for that visit: _____

Why are you seeking dental treatment at this time? _____

Why did you leave your previous dentist? _____

What did you ***like*** about your last dentist? _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- Have you ever had a bad dental experience or had problems with previous dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- When was the last time you had your teeth cleaned? _____
- Have you ever been told / been treated for gum disease (periodontitis)? _____
- When do you brush your teeth? _____ Do you floss each day? _____
- Do you use a soft toothbrush? _____ What kind of toothpaste do you use? _____
- Do you use a mouth rinse (what brand)? _____
- What kind of tobacco products do you use? _____ For how long? _____

  (If you smoke, how much per day?) _____

- Do you use recreational drugs? ☐ Yes ☐ No
- How many times per week do you drink alcohol? Never 7 or less 8-14 14+
- Do you have any popping, clicking, or pain in your jaw joints (TMJs)? _____
- Are there any sores or growths in your mouth? _____
- Are you aware of clenching or grinding your teeth during the day or night? _____
- Have you ever had orthodontic treatment? When and for how long? _____
- Are your teeth sensitive to hot, cold, pressure, or sweets? If so, **which teeth**? _____

_____

- Have you ever experienced difficulty in getting numb for dental treatment? _____
- Do you feel very nervous about having dental treatment? _____
- If you could change anything about your smile, what would you change?

_____

- Are you interested in learning about ways to change the things you don't like about your smile? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have any changes in my health or medications I am taking, I will inform Dr. Chenault at the next appointment without fail.

_____ Date: _____

Signature of patient, parent, or guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____(Work): _____(Cellular): _____

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: _____

_____ Phone: _____

Financial Guidelines

As a condition of your treatment by this office, financial arrangements must be made in advance. Payment is due **at the time of treatment**. Payment options include: cash, personal check, credit card, or Dental Fee Plan (financing option our office makes available to you).

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or credit card at the time services are performed.

As a courtesy, we are happy to accommodate you by filing your insurance claims. We ask that your estimated portion of the fee be paid at the time of treatment. If this does not result in full payment of your account, you will receive a statement for the remaining balance. Dental insurance is a method of partially offsetting treatment fees. Insurance benefits are based on a schedule of fees that is determined by your insurance company and your employer. For this reason, you may receive a lower percentage of reimbursement than indicated in your dental treatment plan. Some insurance companies require that you see an "in network" dentist (we are a network dentist for Delta Dental only); it is your responsibility to know your insurance limitations. We can only give you an **ESTIMATE** of what your dental insurance may cover and can make no guarantee of any estimated insurance coverage. You are responsible for any remaining balance after insurance payment has been received. If after 60 days your insurance company has not paid on the claim, you will be responsible for the total balance. If your account balance becomes severely delinquent (over 90 days), your account may be referred to a collection service, in which case you will be responsible for fees assessed by the collection agency IN ADDITION to your account balance at our office.

A service charge of 1½% per month (18% per annum) on any unpaid balance will be charged on all accounts exceeding 30 days.

I understand I will be charged $30 for any checks returned due to non-sufficient funds or stop payments placed on submitted checks.

I understand that the fee **estimate** listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the value of said services to said Doctor, or her assignee, at the time said services are rendered. I further agree that the value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof, prior to the rendering of said services. 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 my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the Patient HIPAA Consent Form and understand its contents. I understand that I may be given a copy of this form by my request.

We reserve the right to assess a $50 fee to your account if you habitually do not show up to your scheduled appointment or cancel without 24 hours notice.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment / responsible party