BENDEL
FAMILY DENTISTRY
FRANCES CHAUVIN, DDS

Patient Information

Full Name:_____ Date Of Birth:_____ Preferred Name:_____
Address:_____ City:_____ State:_____ Zip Code:_____
SSN:_____ Job/Place of work:_____ Job Title:_____
Cell Phone:_____ Home Phone:_____ Work Phone:_____
Email Address:_____ Marital Status: Married Single Other
Can we text appointment reminders? Y/N Can we email appointment reminders? Y/N
Date of last dental visit?_____ Reason for today's visit?_____
How did you hear about our office?_____

Responsible Party

If patient listed above is responsible party, skip to next section, Parents of minors and caretakers, please fill out.

Full Name:_____Relation:_____ Date of Birth:_____
Address:_____ SSN:_____
Cell Phone:_____ Home Phone:_____ Work Phone:_____
Email Address:_____

Emergency Contact

Full Name:_____ Relation:_____
Best contact number:_____

Dental Insurance Coverage

Insurance Company:_____ Employer for insurance:_____
ID Number on Card:_____ Group Number:_____

If your insurance is through your spouse or parent, please provide their name and date of birth for insurance processing. If you are the main policy holder, skip to next section.

Subscriber/Member Name:_____ Subscriber/ Member Date of Birth:_____

Do you have a secondary dental insurance? Yes ☐ No ☐ If yes, please provide:_____

I certify that I have read and understand the questions above. I acknowledge that my questions have been to my satisfaction.

I will not hold my dentist or any other members of her staff responsible for any errors that I have made in the completion of this form.

Patient:_____ Date:_____

Parent/Guardian (if patient is a minor):_____ Date:_____

OVER →

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HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice Before signing this Consent. The terms of out Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy of Practices.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this consent.

The Consent was Signed by:_____ **Date:**_____
(Printed Name of Patient or Representative)

Signature:_____ **Date:**_____

Relationship to Patient
(if other than Patient):_____

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CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State Law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything.

Any alternatives to the recommended treatment, including no treatment, have been explained to me. In general terms, the following dental treatment or oral surgery procedure(s), diagnostic aids may be performed.

-Preventative hygiene treatment (prophylaxis) and the application of fluoride
-Treatment of diseased or injured teeth with dental restorations (fillings or crowns)
-Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures)
-Removal (extraction) of one or more teeth
-Treatment of diseased or injured oral tissues (hard or soft)
-Use of sedative drugs to control apprehension and/or disruptive behavior
-Treatment of malaposed (crooked) teeth and /or oral developmental or growth abnormalities
-Use of general anesthesia to accomplish the necessary treatment

There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or premedication prior to dental care being rendered. Some risks/complications are, but not limited to the following:

Infection
Bleeding
Failure of wound to heal
Injuries to adjacent teeth and/or soft tissues Paresthesia or numbed of: tongue, and/or mouth, and/or face
Fracture of mandibular (lower jaw) or maxilla (upper jaw) Opening between mouth and sinus or mouth and nose
Tooth or fragment in maxillary sinus
Incomplete removal of tooth
Dry socket, Loss of teeth, loss of bone
Slough (unanticipated loss of hard and/or soft tissue)
Injury or adjacent structures
Instrument breakage
Breakage of root(s) and retained root fragments
Swallowing and/or aspiration of objects
Allergic reaction to drug
Trismus (jaw pain or difficulty opening mouth) Failure of treatment to accomplish its purpose Death (in rare instances)
Bacterial Endocarditis
Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s)

ACKNOWLEDGEMENT

I acknowledge that I have read, or that it has been read to me, and I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction. I hereby authorize the direct Dr. Frances Chauvin and/or her associates, hygienists, assistants to perform the diagnostic, surgical or dental treatment. This consent form will remain valid until revoked me in writing.

Signature: _____Date:_____
Relationship to Patient
(if other than Patient):_____

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FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality of dental care using only the set materials and technology available on the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Thais financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing out administrative costs.

REGARDING PAYMENT

We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, and American express

Payment for services is due at the time services are rendered.

Payment for, crowns, bridges, night guards, full or partial dentures is due at time of service.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing department.

Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee. This fee covers the processing fees that are charged to our office.

Balances older than 30 days may be subject to collection fees and finance charges at the rate of 15% per month. Additionally, our office may charge you for broken appointments and cancellations without a 48 hour advanced notice.

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance has not paid your account in full within 60 days, **THE BALANCE WILL BE TRANSFERRED TO YOUR ACCOUNT.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for out patients and we charge what is usual and customary for our area. **YOU ARE RESPONSIBLE FOR PAYMENT REGARDLESS OF ANY INSURANCE COMPANIES ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES.**

YOUR COMPLETE INSURANCE INFORMATION MUST BE PRESENTED AT THE TIME SERVICES ARE PROVIDED. INSURANCE CLAIMED CANNOT BE BACK DATED. MOST BENEFITS WILL BE VERIFIED BEFORE YOUR INSURANCE COMPANY CAN BE BILLED.

All insurance co-pays and deductibles must be paid at the time of service.

We would be happy to discuss out charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions.

Signature: _____ Date:_____

Relationship to Patient
(if other than Patient):_____

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Have you ever had a joint replacement?	◯ Yes ◯ No	
Date of artificial joint placement		

Women: Are you...

☐ Pregnant ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No	Anxiety/Depression	◯ Yes ◯ No				

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____