CHETWOOD Dental Clinic

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone (Mobile): _____ Work: _____ Home: _____

Email: _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name: _____	Subscriber Name: _____
Subscriber ID: _____	Subscriber ID: _____
Relationship to Subscriber (Circle one): Self Spouse Child Other	Relationship to Subscriber (Circle one): Self Spouse Child Other
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____
Employer Name: _____	Employer Name: _____
Insurance Company: _____	Insurance Company: _____
Insurance Group: _____	Insurance Group: _____
Insurance Phone Number: _____	Insurance Phone Number: _____

Please be ready to present your insurance card and ID to be photo-copied for our records.

RESPONSIBLE PARTY (If the patient is a minor)

Last Name: _____ First: _____ Initial: _____

Address (if different): _____ City: _____ State: _____ Zip Code: _____

Telephone (Mobile): _____ Work: _____ Home: _____

Email: _____

EMERGENCY CONTACT

Last Name: _____ First: _____ Initial: _____

Contact Number (circle one): Mobile Work Home _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS:
I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails.

I attest to the accuracy of the information on this page.

Signature: _____ Date: _____
(*Responsible Party signs if patient are under 18 years of age)*

CHETWOOD Dental Clinic

TREATMENT PLAN: I understand that I may be having the following work done but not limited to: Fillings, Periodontal treatment, Crowns, Extractions, Root Canals, Dentures, X-Rays, Surgery, Implants, and Orthodontics.

CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. I give permission to the dentists at Chetwood Dental Clinic to make any changes and additions necessary.

NITROUS OXIDE: I understand that nitrous oxide may cause nausea, vomiting, and headaches. It is my responsibility to inform my treating practitioner if I am pregnant, use marijuana, hallucinogenic drugs, or have COPD or any breathing disorder which are contraindicated.

LOCAL ANESTHESIA: I understand that local anesthesia is recommended for most of the procedures performed and its benefits far outweigh the potential risks, however I am aware that it can result in allergic reaction and life threatening anaphylactic shock. Furthermore, it can result in permanent damage to the nerve, partial or complete permanent numbness lasting several days to months, bruising or formation of hematoma.

SEALANTS: I understand sealants are a preventative measure intended to facilitate the inhibition of dental caries in the pits and fissures of the chewing (occlusal) surfaces of the teeth. There is a possibility of the sealant de-bonding or becoming dislodged over a period of time. This time varies depending on the chewing forces, types of food chewed, and inadequate oral hygiene.

WHITENING TREATMENT: There may be sensitivity associated with the whitening procedures done in the office (zoom) and at home (trays, strips, and pen). It is a common consequence of whitening. Patient is advised to take analgesics and treat the area with topical fluoride until sensitivity subsides.

PERIODONTAL CLEANING/SCALING AND ROOT PLANING: I understand that the most common complications are pain, bleeding, tissue (gum) laceration, sensitivity to temperature or foods, swelling, ulceration (infection), tooth fracture, breaking of fillings, dislodging of crowns or veneers.

PERIODONTAL LOSS (TISSUE AND BONE): I understand that I may have a serious condition, causing gum inflammation, bone loss, and it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, bone grafts,, extractions, laser treatment and bacterial irrigation. Any dental procedures may have future adverse effects on my periodontal condition.

RESTORATIVE TREATMENT: I understand that the most common complications are pain, sensitivity to temperature, fracture of tooth, nerve damage, damage to other teeth, occlusal (bite) discrepancies, TMJ complications, reactions to drugs/ anesthesia. I understand that sometimes existing caries may cause inflammation of the nerve and subsequently filling restorations may have to be further treated by a root canal therapy due to initial underlined inflammation of the nerve. Also I understand that once the tooth is restored with a filling material it is never going to feel the same as natural tooth.

CROWNS/ BRIDGES: I understand that sometimes it is not possible to match the color of the artificial teeth exactly to natural teeth. I further understand that I may be wearing temporary crowns/ fillings that may come off easily and I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize that the final opportunity to make changes to my restoration (including shape, size, fit and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from the preparation date. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be an additional charge for remakes due to me delaying permanent cementation.

ENDODONTIC TREATMENT (PULPOTOMY/ROOT CANAL): I understand that there is no guarantee that root canal treatment will save my tooth, and the complications can occur from the treatment. Occasionally root canal filling materials may extend through the the tooth, which does not necessarily, affect the success of treatment. I understand that the tooth may be lost in spite of all the efforts to save it. Root canal treated teeth must be covered by crowns or bridges and if I do not follow the post-operative instructions, it could lead to a fracture and failure of root canal treated tooth.

STAINLESS STEEL CROWNS: I understand that SSCs need further treatment in the future, such as extractions and/or space maintainers. There may be damage to adjacent teeth and/or tissues. They may also cause changes in the bite.

I have read the above statements and understand the risks, benefits, and possible complications of dental treatments. I have been advised and understand my treatment options. I also understand that complications could change the treatment plan. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment by which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction.

I agree and consent to the judgment of the dentists and staff at Chetwood Dental Clinic in performing my dental treatments.

Signature: _____Date:_____
(*Responsible Party signs if patient are under 18 years of age)*

INFORMED CONSENT FOR DENTAL TREATMENT

PATIENT NAME: _____ **DATE:** _____

Chetwood Dental Clinic is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT THE TIME OF SERIVCE**
- **WE ACCEPT CASH, VISA, MASTERCARD, DISCOVER, AND CARE CREDIT.**
- **CHETWOOD DENTAL CLINIC PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT'S PORTION OF PARTICUALR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERIVICE.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians are responsible for full payment at the time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover.

INSURANCE

CDC provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. The amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year, If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not reply upon any information provided by the Chetwood Dental Clinic's staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have been assigned those benefits to Chetwood Dental Clinic. However, if you are paid by the insurance instead of Chetwood Dental Clinic, you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available to the best of our abilities.

You as a patient are always responsible for any charges that are not covered by your insurance.

MEDICARE/MEDICAID/CHIP

If you are covered by Medicare, Medicaid, or CHIP: please contact our office staff prior to arriving at Chetwood Dental Clinic on the date of service to discuss your payment situation.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding for at least 30 days. In addition, all payments returned due to non-sufficient funds will be subjected to a NSF fee of $25.00.

MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $35 per each 30 minutes of missed appointment time. Please help us service you better by keeping schedule appointments.

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

Signature: _____ Date: _____
(*Responsible Party signs if patient are under 18 years of age)*

FINANCIAL POLICY

CHETWOOD Dental Clinic

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number; _____ Social Security Number: _____

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY (FOR THE PATIENT)

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide to sign this Consent. Our notice provides a description of our treatment, payment, activates, and healthcare operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices with the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy o four Notice of Privacy Practices, including any revisions of our Notice at any time by contacting :

Compliance Officer:	**Lan Doan, D.D.S., M.S.D.**
Telephone:	**713-839-0919, Fax: 281-498-1108**
Address:	**6910 Chetwood Drive, Suite B, Houston, TX 77081**

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, _____ have had a full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf o the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request Chetwood Dental Clinic to restrict the disclosure of my PHI to those specified below:

Name: _____

Name: _____

Signature: _____ Date: _____

If this Restriction is signed by a personal representative (parent/guardian) on behalf o the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

CHETWOOD Dental Clinic

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason(s) for today's visit: _____ Date of last visit: _____
Former Dentist: _____ Date of last Dental X-rays: _____

Please circle if you have/had:	**Yes**	**No**		**Yes**	**No**
Bad breath	Yes	No	Head, neck, jaw pain or aches	Yes	No
Blisters on the lips or mouth	Yes	No	Lip or cheek biting	Yes	No
Burning sensation on the tongue	Yes	No	Loose teeth/broken fillings	Yes	No
Chew on one side of the mouth	Yes	No	Mouth breathing	Yes	No
Use cigarette, pipe, or cigar smoking	Yes	No	Orthodontic treatment	Yes	No
Dry Mouth	Yes	No	Nitrous oxide in the past	Yes	No
Food collection between teeth	Yes	No	Periodontal treatment in the past	Yes	No
Clench/grind teeth	Yes	No	Sensitivity to pressure/irritants	Yes	No
Growths or sore spots in the mouth	Yes	No	(cold, heat, sweets)		
Gums swollen, tender, or bleeding	Yes	No			

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics (please circle one)? Yes No

If yes, please explain: _____

_____

Have you ever had trouble from your previous dental care (please circle one)? Yes No

If yes, please explain: _____

_____

MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____
Physician's phone and address: _____
Have you had any serious illnesses or operations (please circle one)? *Yes* *No* If yes, please describe: _____
Have you ever had a blood transfusion (please circle one)? *Yes* *No* If yes, please give approximate dates: _____
Women: Are you pregnant (please circle one)? *Yes* *No* Due date: _____ Nursing? *Yes* *No* Taking birth control pills? *Yes* *No*

Please circle if you have/had:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Allergies, hay fever, sinusitis	Yes	No	Headaches	Yes	No	Sickle cell anemia	Yes	No
Anemia	Yes	No	Heart murmur	Yes	No	Skin rash	Yes	No
Arthritis/Rheumatism	Yes	No	Heart problems	Yes	No	Slow healing wounds	Yes	No
Artificial joints	Yes	No	Hepatitis type ___	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Herpes	Yes	No	Swelling of feet/ankles	Yes	No
Required hospitalization	Yes	No	High blood pressure	Yes	No	Thyroids problems	Yes	No
Have you used steroids?	Yes	No	Immune Deficiency	Yes	No	Tonsillitis	Yes	No
Date of last episode: _____			Jaundice	Yes	No	Tuberculosis	Yes	No
Bleeding abnormally with operations?	Yes	No	Kidney disease	Yes	No	Tumor/growth on head/neck	Yes	No
Blood disease, clotting disorders	Yes	No	Low blood pressure	Yes	No	Ulcer	Yes	No
Cancer	Yes	No	Mitral valve prolapse	Yes	No	Venereal disease	Yes	No
Chemical dependency	Yes	No	Osteoporosis	Yes	No	Unexplained weight loss	Yes	No
Chemotherapy	Yes	No	Osteopenia	Yes	No	Under a care of a physician?	Yes	No
Circulatory problems	Yes	No	Pacemaker	Yes	No	Allergic/sensitive to latex?	Yes	No
Cortisone treatments	Yes	No	Radiation treatments	Yes	No	Allergic to penicillin/aspirin/other drugs?		
Diabetes	Yes	No	Respiratory disease	Yes	No	Yes No		
Emphysema	Yes	No	Rheumatic fever	Yes	No	If yes, please specify: _____		
Epilepsy	Yes	No	Scarlet fever	Yes	No	_____		
Fainting	Yes	No	Shortness of breath	Yes	No	_____		
Glaucoma	Yes	No	Sinus trouble	Yes	No			

Please list any medications you are taking: _____

_____

AUTHORIZATION AND RELEASE

I have read and answered the questions above to the best of my knowledge.

Patient/responsible party signature: _____ Date: _____

Reviewed by: _____ Date: _____

CHETWOOD
Dental Clinic