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COSMETIC & FAMILY DENTISTRY
6900 TURKEY LAKE ROAD
SUITE 1-9
ORLANDO, FL 32819

How did you hear about us________________ Today's Date ____/____/____

PATIENT INFORMATION

Patient Name ________________ If Minor, Parent/Guardian Name ________________

Birthday____/____/____ SS# ____-____-____ DL# ________________

Email Address ________________ Occupation________________

Home Address ________________ City________________ State________ Zip________

Business Address ________________ City________________ State________ Zip________

Home Phone ( ) ____-____ Work Phone ( ) ____-____ Mobile/Pager ( ) ____-____

Emergency Contact________________ Relationship________________ Phone ( ) ____-____

Insurance Company________________ Insurance Company Phone ( ) ____-____

Physician Name________________ Physician Phone ( ) ____-____ Date of Last Exam ____/____/____

Please answer the following:

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If Yes, please list ________________	☐	☐
4. Do you drink?	☐	☐
5. Do you use tobacco?	☐	☐
6. Have you ever used drugs for recreational purposes or been in a substance rehab program?	☐	☐
7. Do you wear corrective glasses or contact lenses?	☐	☐

8. Are you allergic to the following?	YES	NO
Local anesthetics (e.g. Novocain)	☐	☐
Barbiturates	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐
Sedatives	☐	☐
Latex Sensitivity	☐	☐
Sulfa Drugs	☐	☐
Iodine		
Other		

9. WOMEN ONLY	YES	NO
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking birth control pills?	☐	☐

Signature of Dentist Date

Do you have a history of the following?

	YES	NO		YES	NO		YES	NO		YES	NO	
High blood pressure	☐	☐	Diabetes	☐	☐	Easily Fatigued	☐	☐	Stroke	☐	☐	Other
Heart attack	☐	☐	Kidney Diseases	☐	☐	Anemia	☐	☐	Hay Fever/Allergies	☐	☐	
Rheumatic Fever	☐	☐	AIDS or HIV infection	☐	☐	Cancer	☐	☐	Tuberculosis	☐	☐	
Swollen Ankles	☐	☐	Thyroid Problem	☐	☐	Arthritis	☐	☐	Radiation Therapy	☐	☐	
Fainting/Seizures	☐	☐	Hear Disease	☐	☐	Joint Replaced or Impaired	☐	☐	Glaucoma	☐	☐	
Asthma	☐	☐	Cardiac Pacemaker	☐	☐	Hepatitis/Jaundice	☐	☐	Recent Weight Loss	☐	☐	
Low Blood Pressure	☐	☐	Heart Murmur	☐	☐	Sexually Transmitted Disease	☐	☐	Liver Disease	☐	☐	
Epilepsy/Convulsions	☐	☐	Angina	☐	☐	Stomach Troubles/Ulcers	☐	☐	Heart Trouble	☐	☐	
Leukemia	☐	☐	Emphysema	☐	☐	Chest Pains	☐	☐	Respiratory Problems	☐	☐	
						Shortness of Breath	☐	☐	Osteoporosis	☐	☐	

PATIENT DENTAL HISTORY

Last Dental Visit____/____/____	YES	NO
1. Do your gums bleed while brushing and flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you have pain affecting any teeth, your gums, or other areas of your mouth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you ever experienced the any of the following problems in your jaw?	☐	☐
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐

Last Teeth Cleaning by Dental Professional ___/___/____	YES	NO
Do you have frequent headaches?	☐	☐
Do you clench of grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you had any orthodontics work?	☐	☐
Have you ever had prolonged bleeding following extractions?	☐	☐
Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
Have you ever had instruction on the care of your gums?	☐	☐
Have you ever had teeth whitening or other cosmetic dental procedures?	☐	☐

I certify that I have read and understood the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X________________________________ ___/___/____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE

A FAMILY DENTAL CARE
WELCOME TO OUR OFFICE

We would like to thank you for choosing our office for your dental care. If it our objective to make your visit as pleasant as possible and provide you with quality dental care.

HEALTH HISTORY

All patients or parents of minor patients will be asked to complete a health history record.

EXAMINATION

Diagnostic x-rays will be taken and developed immediately. The Dentist will examine the teeth and surrounding tissues. Treatment of this case will be discussed.

FEES

1. There will be an examination fee charged.
2. Fees will vary with the complexity of difficulty of treatment.
3. Fees are quoted in advance of treatment.
4. Fees, once quoted, remain the same unless treatment is delayed (at the request of the patient) for a long period of time or your insurance changes
5. **There is a $35 fee for broken appointments**

METHOD OF PAYMENT

Payment is due at the time of treatment. If you have an Indemnity or PPO insurance plan, and benefits are confirmed and/or pre-authorized prior to treatment, the difference between the estimated amount and the dental fee paid by your insurance will be due at the time of treatment. Any balance left unpaid by the insurance company is the full and immediate responsibility of the patient.

CONSENT AND INFORMATION FORM

It is our belief in this office that you should be informed about the treatment and you should give your consent before starting treatment. The purpose of this form is to tell of the risk that may occur in the dental treatment and explain our office policy.

RISK OF DENTAL PROCEDURES

Included (but no limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth. Thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, vomiting, allergic reaction, itching, bruises, delayed healing, sinus complications and further surgery. Medications and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device or work for twenty-four hours or until recovered from their effects.

ALTERNATIVE TREAMENT CHOICES

They will be discussed with you when possible. They may include: no treatment, waiting for more definite development of symptoms, or having the tooth removed. Treatment will be done in a manner to minimize or avoid risks as success cannot be guaranteed.

I understand that upon completion of my treatment I will be advised to return every 3-6 months for preventive care. I, the undersigned being the patient (parent or guardian of a minor patient) consent to the performing of the procedures decided upon to be necessary or advisable in the opinion of the Dentist

DUE TO OSHA REGULATIONS, ONLY THE PATIENT IS ALLOWED IN THE TREATMENT AREA. PARENT'S SHOULD REMAIN IN THE WAITING AREA UNTIL THEY ARE CALLED. CHILDREN MAY NOT BE LEFT IN THE WAITING ARE WITHOUT AN ADULT. THIS IS FOR THE SAFETY OF PATIENTS AND STAFF.

Patient Name______________________ ______________________ Date ____/____/____

(print) (signature)

Dr. Ravi Oberoi, D.M.D.
Cosmetic & Family Dentistry
6900 Turkey Lake Suite I-9
Orlando, Fl. 32819
(407) 352-7700

Financial and Privacy Policy

1. All payments are due at the time Dental services are started unless alternate arrangements are made prior to the treatment.
2. Insurance balances are ultimately the patient's obligation. We file (most) insurances at no cost to you as a courtesy. We are glad to offer this service. However, insurance balances that are not paid after 60 days may be billed directly to you. I understand that it is solely my responsibility to confirm which treatments or procedure are covered by my insurance including, but not limited, any applicable exclusions or deductible or annual or lifetime maximums.
3. I understand that the insurance estimate may differ from what my insurance carrier ultimately pays and that I am responsible for any amount not paid by my insurance.
4. Patient balances that go unpaid for 90 days or more may incur the following Additional charges: interest charges (1.5% per month or 18% APR), collection fee and /or legal fees.
5. Major services require a deposit of at least half the estimated patient portion at the time the appointment is made.
6. A fee of $35.00 may be charged for appointment cancellation done in fewer than 24 hours notice or for no shows with any notification
7. A fee of $30.00 will be assessed for returned checks.
8. All original x-rays become property of this office; duplicate copies for digital x-rays on a CD are available for $25.00 which is to be pre-paid at the time of written request for duplication. Please allow 2 to 7 working days for this. There will be no fee for copy of x-rays on paper.
9. Discontinue treatment for a requested procedure including but no limited to, partials, Dentures, crowns, bridgework and surgical preparatory work, I remain responsible for paying all lab related costs for material and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund to which I may be entitled.
10. Patient must inform timely Cosmetic and Family Dentistry in writing, of any changes to my address, phone number, work contact information , work status, insurance changes, and update any changes in medical history.

11. If I fail to pay any balance on my account in timely manner, Cosmetic and Family dentistry may report my account to credit rating bureaus or to a collection agency and /or take legal Action against me for full payment including, but not limited to, all related reasonable Attorney's fees, collection and/or court costs.

12. I authorize Cosmetic & Family Dentistry and its staff to discuss my treatment plan, fees, appointment or anything related to my dental record with:

    Spouse (name) ____________________
    Any other family member (name)____________________
    Other____________________
    Information not to be released to any one____________________

____________________ Patient Signature

____________________ Date

Acknowledgement of Notice of Privacy Practices

I have read, understood, and have acknowledged the Notice of Privacy Practices and had an opportunity to ask questions.

____________________ Patient signature

____________________ Date