Pranati S. Chokshi, D.M.D., P.A.
11157 W. Colonial Drive ~ Ocoee, FL 34761
(407)654-9905

Patient Information

We appreciate the confidence you have placed with us to provide dental care.
All the information on this chart is necessary for our records and is strictly confidential.

Patient -First:_____ **MI:**_____**Last:**_____**Preferred:**_____

Address:_____**Apt #**_____**City:**_____ **State:**_____ **ZIP:**_____

DOB:_____ **Male / Female** **Marital Status:**_____ **Spouse Name:**_____

Home Phone (____)_____ **Cell Phone (____)**_____ **Work Phone (____)**_____**ext**_____

Employer:_____ **Work Address:**_____**City**_____**Zip**_____

E-mail:_____ **Social Security #:** _____ **Employer:** _____

Responsible Party/Policy Holder:_____ DOB_____ Relation:_____

SSN:_____ **ID#** _____**Insurance Co:**_____ **Group #**_____

Please let us know how you heard about us: Friend/Relative_____ ☐ Signage ☐ Insurance Company

☐Yellow Pages ☐Advertising ☐Internet:(keywords used)_____☐ Other:_____

EMERGENCY CONTACT: _____ Phone:_____ Relation:_____

Dental Health History

The information you provide is important for your dental health. If there have been any changes in your health, please tell us. If you have any questions, do not hesitate to ask. Please answer YES or NO to the following questions:

	YES	NO
Are you having any discomfort?	☐	☐
Sensitivity to hot, cold, sweets, chewing?	☐	☐
Does dental treatment make you nervous?	☐	☐

Have you experienced any of the following problems?

Snoring problem	☐	☐
Bleeding gums	☐	☐
Bad breath	☐	☐
Grinding of teeth		
Jaw pain	☐	☐
Headaches	☐	☐

Do you have difficulty brushing your teeth due to the following?

Arthritis	☐	☐
Difficulty in reaching back teeth	☐	☐
Uncontrolled hand movement	☐	☐
Other:_____		

Patients with Denture or Partial:

Do you wear a denture/partial?	☐	☐
How old is your denture/partial?	☐	☐
Have you relined your dentures before?	☐	☐
Does your denture cause irritation or soreness?	☐	☐
Have your dentures ever broken or cracked?	☐	☐
If you wear a partial, did you ever break a clasp?	☐	☐
Do You use a denture cleaner?	☐	☐
Are your dentures loose?	☐	☐
Do you use any denture adhesive?	☐	☐

Patient/Guardian Signature: _____

	YES	NO
Have you ever had Periodontal Therapy?	☐	☐
Are your teeth turning yellow or losing brightness?	☐	☐
Do you smoke? # of packs per day_____	☐	☐
Do you drink coffee or tea?	☐	☐

If I could change my smile I would make my teeth:

Whiter	☐	☐
Remove white spots	☐	☐
Close space/spaces	☐	☐
Replace stained front fillings	☐	☐
Change silver fillings to white	☐	☐
Repair chipped teeth	☐	☐
Replace missing tooth/teeth	☐	☐
Straighten teeth	☐	☐
Other_____		

Do you take fluoride supplements?	☐	☐
Do you prefer to save your teeth?	☐	☐

Date of last cleaning:_____
Are you experiencing pain at this time, if so where?_____

Please describe:_____

Please explain reason for your visit today: _____
_____
_____
_____

Date:_____

rev-5/16

Time 8:39 AM | Pranati S. Chokshi D.M.D,P.A | Date 4/2/2015

Eaglesoft Medical History

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	

Women: Are you...

☐ Pregnant/Trying to get 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 use controlled substances?	○ Yes ○ No	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

Have you ever had any serious illness not listed ○ 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:_____

Pranati S. Chokshi, DMD, PA
11157 West Colonial Drive Ocoee, FL 34761
407.654.9905

DENTAL TREATMENT CONSENT FORM

Please read and initial below and read and sign the section at the bottom of the form.

1. **Work to be done**
   I understand that I am having the following work done:
   Fillings_____Bridge_____Crown_____Extractions_____Impacted Teeth Removed_____ Local Anesthesia____ Root Canals_____ X-Rays_____Other_____ **INITIALS_____**
2. **Drugs and Medications**
   I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (Severe allergic reaction)
   INITIALS_____
3. **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 examination, the most common being root canal therapy following routine restorative procedures. I gave my permission to the dentist to make any/all changes and additions as necessary.
   INITIALS_____
4. **Dentures, Complete or Partial**
   I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breaking. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "Teeth in wax" try in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fees. I have also been explained the alternatives for dentures/partials including implant supported dentures. I am also aware in order to warrantee any prosthesis I will participate in regular exams and cleanings as diagnosed by my dentist. If I do not follow through with the hygiene protocol, the warranty will automatically be voided. **INITIALS_____**
5. **Fillings**
   I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common a side effect after a newly placed filling. I also understand that fillings can turn into Root Canal treatment during or after the procedure. That means extra treatment at additional cost might be needed. I also understand that sometimes I might need to extract tooth if decay is too far and/or I cannot afford to do Root Canal treatment.
   INITIALS_____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment 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 consent to the proposed treatment.

Signature of Patient_____ Date_____

Pranati S. Chokshi, DMD, PA

11157 West Colonial Drive Ocoee, FL 34761

407.654.9905

Our Financial Policy

Patient Name_____ Parent/Guardian Name_____

Full Payment Is Due At Time of Service

We Accept Cash, Credit, Debit Cards (Visa, MasterCard, Discover and American Express)NO PERSONAL CHECKS

Regarding Insurance

Your insurance is a contract between you and the insurance company. We are not a party to that contract. Dental insurance is not meant to be a pay-all option, but meant to be an aid. So please, be aware that some and perhaps all of the services provided under your particular policy may be considered "Non-Covered Benefits" above their "Usual and Customary Fee" or based on a set "Fee Schedule". Your benefits are dependant on how much you or your employer paid for your particular plan. If you have any questions regarding the details of your plan, we ask that you contact you company. Regardless of what insurance pays, the final balance on your account is considered your responsibility. We are happy to assist you in receiving you maximum allowable benefits and require all pertinent insurance information to be given to us so that eligibility and general benefits can be verified. Once confirmed, our office will be able to accept assignment of benefits and bill your insurance company directly as a courtesy to you. Please understand that we cannot predict exactly what your insurance company will pay on a particular procedure or service and only an estimate can be determined of the charges based on the information your insurance company is willing to provide. An annual deductible and any required co-payment on a particular service will have to be collected at time of service, and can only be based the general information released by your insurance company. We will bill your insurance company as services are rendered. Payment is expected within 45 days of that billing. Any services not paid within 45 day wait period will become immediately due in full. Any unpaid accounts 30 days past due will be subject to a $5.00 monthly billing service charge.

Usual and Customary Rates

Our practice is committed to providing the best treatment for out patient and we charge what is usual and customary for our area. You are responsible for any payment regardless of and insurance company's arbitrary determination of usual and customary rates. Dental insurance usually covers Basic dental procedures, complex comprehensive procedures and cosmetics are often times "Non-Covered Services".

Change or Termination Of Insurance

If your insurance coverage changes or is terminated, please notify our office immediately so we can update your information.

Cancellation of Appointment

If for any reason you are unable to keep your appointment, kindly give us 24 hours notice. Without 24 hours notice your account will be charge $75 /hour fee for the time blocked for your treatment after the second cancelled appointment.

Duplication of Records

There will be a $35.00 charge for transfer or duplication of records, with signed Record release.

We are committed to providing our patients with the best possible care and our professional recommendations cannot be dictated or limited by insurance coverage.

I have had the opportunity to read this form, ask questions, understand and agree to the terms of the financial policy. I am responsible for payment of dental fees. I agree attorney's fees, collection fees, or any cost that may be incurred to satisfy this obligation.

Signature of patient/legal guardian _____ Date _____

PRANATI S. CHOKSHI, DMD, PA

HIPAA ACKNOWLEDGE

11157 WEST COLONIAL DRIVE OCOEE, FL 34761
407.654.9905

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

I HAVE READ/RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES OF THIS OFFICE.

PATIENT'S NAME-PLEASE PRINT

PERSON I AM AUTHORIZING TO RECEIVE INFORMATION REGARDING MY TREATMENT, APPOINTMENTS, OR DENTAL CARE FROM THIS OFFICE:

NAME _____ Relationship _____

PATIENT'S SIGNATURE DATE

PLEASE NOTE: IT IS YOUR RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

FOR OFFICE USE ONLY

WE TRIED TO OBTAIN WRITTEN ACKNOWLEDGEMENT BY THE INDIVIDUAL NOTED ABOVE OF RECEIPT OF OUR NOTICE FO PRIVACY PRACTICES, BUT IT COULD NOT BE OBTAINED BECAUSE:

_____AN EMERGENCY PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT

_____A COMMUNICATION BARRIER PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT

_____THE INDIVIDUAL WAS UNWILLING TO SIGN

_____OTHER