WELCOME

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form.
If you have any questions or need assistance, please ask us!

PATIENT INFORMATION

Date

Name: ______________________ Birthdate: ____________ Social Security #:: ____________

Address: ______________________ City: ____________ State: ______ Zip: ____________

Sex: ☐ M ☐ F ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: (___) ____________ Cell Phone: (_____) ____________ Work Phone: (____) ____________

Best Time to Call: ☐ Morning ☐ Afternoon Preferred Contact Method: ☐ Phone Call ☐ Text message ☐ Email

Email: ______________________

If student name of school: ____________ City: ____________ State: ____ Full time ☐ Part Time ☐

Employer: ______________________ Address: ______________________

Spouse/Parent/Guardian's Name: ______________________ Number: (___) ____________

Whom may we thank for referring you? ______________________

Person to contact in case of emergency: ____________ Phone: (___) ____________ Relationship: ________

RESPONSIBLE PARTY

Name of Person Responsible for this account: ______________________ Relationship to Patient: ____________

Address: ______________________ Home Phone: (_____) ____________

Birthdate: ____________ Employer: ____________ Currently a patient in the office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured: ______________________ Relationship to Patient: ____________

Birthdate: ____________ Social Security # ____________ Date Employed: ____________

Employer: ______________________ Phone Number: (____) ____________

Employer Address: ____________ City: ____________ State: ______ ZIP: ____________

Insurance Company: ____________ Group #: ____________ Group Name: ____________

Address: ____________ City: ____________ State: ______ ZIP: ____________

ADDITIONAL INSURANCE

Name of Insured: ______________________ Relationship to Patient: ____________

Birthdate: ____________ Social Security # ____________ Date Employed: ____________

Employer: ______________________ Phone Number: (____) ____________

Insurance Company: ____________ Group #: ____________ Group Name: ____________

Address: ____________ City: ____________ State: ______ ZIP: ____________

Medical History

Although dental personnel primarily treat the area 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.

Name: ________________________________ **Phone:** __________________ **Date of last medical exam:** ________________

What was the exam for? ______________________________________ **Current Physician**: ______________________________

Have you ever been hospitalized or had a major operation?	Yes	No
Are you under the care of a physician?	Yes	No
Have you ever had a serious head or neck injury?	Yes	No
Are you taking any medications or supplements?	Yes	No

Women

	Y	N
Are you pregnant or try to get pregnant?	☐	☐
Are you taking contraceptives?	☐	☐
Are you Nursing?	☐	☐

If yes, please list the medication, dose, & how often: ________________

____

Do you take, or have you taken Phen-Fen or Redux?	Yes	No
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Yes	No
Are you on a special diet?	Yes	No
Do you use Tobacco?	Yes	No
Do you use controlled substances?	Yes	No

Are you allergic to any of the following?

☐ Aspirin ☐ Metal
☐ Penicillin ☐ Latex
☐ Local Anesthetics ☐ Sulfa Drugs
☐ Acrylic ☐ Other: ______________
☐ Codeine ☐ NONE
☐ Food Allergies: __________________________

____

CIRCLE ALL THAT APPLY:

Acid Reflux	Yes	No
AIDS\HIV Positive	Yes	No
Alzheimer's Disease	Yes	No
Anaphylaxis	Yes	No
Anemia	Yes	No
Angina	Yes	No
Arthritis\Gout	Yes	No
Artificial Heart Valve	Yes	No
Artificial Joint:	Yes	No
What Joint? ______________________		
When? __________________________		
Asthma	Yes	No
Blood Disease	Yes	No
Blood Transfusion	Yes	No
Breathing Problem	Yes	No
Bruise Easily	Yes	No
Cancer	Yes	No
Type? __________________________		
Chemotherapy	Yes	No
When? __________________________		
Chest Pains	Yes	No
Cold Sores\Fever Blisters	Yes	No
Congenital Heart Disorder	Yes	No
Convulsions	Yes	No
Cortisone Medicine	Yes	No
Diabetes	Yes	No
Drug Addiction	Yes	No
Dry Mouth	Yes	No
Easily Winded	Yes	No
Emphysema	Yes	No
Epilepsy\Seizures	Yes	No
Excessive Bleeding	Yes	No
Excessive Thirst	Yes	No
Fainting Spells\Dizziness	Yes	No
Frequent Cough	Yes	No
Frequent Diarrhea	Yes	No
Frequent Headaches	Yes	No
Genital Herpes	Yes	No
Glaucoma	Yes	No
Hay Fever	Yes	No
Heart Attack\Failure	Yes	No
Heart Murmur	Yes	No
Heart Pace Maker	Yes	No
Heart Trouble\Disease	Yes	No
Hemophilia	Yes	No
Hepatitis A	Yes	No
Hepatitis B or C	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Hives or Rash	Yes	No
Hypoglycemia	Yes	No
Inflammatory Disease	Yes	No
Type? __________________________		
Irregular Heartbeat	Yes	No
Kidney Problems	Yes	No
Leukemia	Yes	No
Liver Disease	Yes	No
Low Blood Pressure	Yes	No
Lung Disease	Yes	No
Mitral Val. Prolapse	Yes	No
Osteoporosis	Yes	No
Jaw Pain	Yes	No
Parathyroid Disease	Yes	No
Psychiatric Care	Yes	No
Radiation Treatments	Yes	No
When? ______________________		
Recent Weight Loss	Yes	No
Renal Dialysis	Yes	No
Rheumatic Fever	Yes	No
Scarlet Fever	Yes	No
Shingles	Yes	No
Sickle Cell Disease	Yes	No
Sinus Trouble	Yes	No
Sleep Apnea	Yes	No
Do you wear a c-pap?	Yes	No
Spina Bifida	Yes	No
Stomach Disease	Yes	No
Stroke	Yes	No
Swelling of Limbs	Yes	No
Thyroid Disease	Yes	No
Tonsillitis	Yes	No
Tuberculosis	Yes	No
Tumors or Growths	Yes	No
Ulcers	Yes	No
Venereal Disease	Yes	No
Yellow Jaundice	Yes	No

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ **YES** ☐ **NO**

If yes, please explain: ____

____

____

FAMILY HISTORY UNKNOWN? ☐ **YES** ☐ **NO**

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 the medical status.

Signature of Patient, Parent, or Guardian: ____ **Date**:__________________________

Shady Spring Dental Care
Consent for Treatment/Financial Agreement

Consent for treatment:

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with my treatment and further authorize and consent that the Doctor choose and employ such assistance as deemed fit. I also understand that the use of anesthetic agents embodies a certain risk. By signing below, you consent to treatment at this office and any other satellite office under common ownership. This consent is continuing and will remain fully effective until it is revoked by you in writing.

Patient Name: ____ Date: ___________________

Patient/Guardian: ______________________________________Date: ___________________

Financial Agreement:

I understand that responsibility for payment for the dental services provided for myself/family members is mine, due and payable at the time of service. I further understand that a 1.5 % finance charge will be added to any balance over 90 days. We will bill your insurance as a courtesy to you, but we cannot guarantee benefits or payment from them. Your dental insurance policy is a contract between you, your employer and your insurance company. It is your responsibility to thoroughly understand the coverages and exceptions of your policy and to provide us accurate information. We will do our best to assist you with your plan and maximize your benefits. A parent or legal guardian must accompany a child under the age of 18 for dental treatment. The parent that brings the child in is responsible for payment. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and attorney fees that may be required for collection of this note.

Patient Name: ____ Date: __________________

Patient/Guardian: ____ Date: __________________

Confirmation/Cancellation Agreement

Our scheduling team makes every effort to schedule your treatment at a time that is most convenient for you. When your dental needs are diagnosed, if left untreated over time, they may get worse. Therefore, it is very important that you keep your appointment as scheduled. Our patients understand and appreciate our confirmation/cancellation agreement and the positive effects it has on our practice. It allows us to best treat our patients in a timely manner.

In order to hold an appointment for you we do require **confirmation**. You will have the opportunity to confirm your appointment with us up to **14 days prior** by text, email or phone call, whichever you prefer. We request confirmation at least **3 days** before the scheduled appointment. If we do not receive confirmation, you will forfeit your appointment, and you will need to reschedule by calling our scheduling team.

Shady Spring Dental Care is committed to improving your oral health. We understand that situations arise that may require you to change an appointment; however, we request **48-hour notice,** except in the case of emergencies. If you need to make an appointment change, our agreement concerning cancelled or failed appointments is as follows:

- A patient with an appointment must call at least **48 hours** in advance prior to canceling or rescheduling his or her appointment. A $40 fee for broken appointments violating this agreement may be incurred.
- After the **THIRD cancellation** violating this policy within a **6-month** period, we will provide treatment for 30 days on an emergency-only basis. At that time, we will give you an opportunity to find another dental office to take care of your dental needs.

I, ____________________ (print name of responsible party), understand and agree to this policy.

______________________________ ____________________

Signature Date

HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: ____