SHAPIRO
FAMILY DENTISTRY
"Creating Miles of Smiles"

Date: _____ Home Phone (____) _____

Cell Phone (____) _____

PATIENT INFORMATION

Name_____ SS/HIC/Patient ID #_____
Last First Middle Initial

Address_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Email:_____ ☐ Separated ☐ Divorced ☐ Partnered for ____ yrs

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Employer Phone_____

Whom may we thank for referring you?_____

In case of emergency, who should be notified? _____Phone_____

Pharmacy Name & Address: _____Phone_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last First Middle Initial

Relation to Patient_____ Birthdate_____ SS#_____

Address if different from Patient's_____Phone _____

City_____ State_____ Zip_____

Person Responsible Employed By_____ Occupation_____

Business Address_____ Business Phone_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan_____

HELP US HELP YOU

Do you like your smile? _____ Yes _____ No

If you could change your smile, what would you like to change?

_____ The color of my teeth _____ Close spaces or restore worn and broken teeth

_____ The shape of my teeth _____ The position or alignment of my teeth

_____ Other, please specify: _____

I am interested in: _____ Teeth Whitening _____ Cosmetic Evaluation _____ Replacement of Missing Teeth

_____ Straight Teeth _____ Implants _____ Other, please specify: _____

This office charges a missed appointment fee of $25.00 - we appreciate a 48-hour courtesy call to cancel your appointment.

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Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: _____

Are you now under a doctor's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam ____/_____/_____

Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?_____

Have you ever had surgery? Yes No
If yes, when and what for? Date of surgery:_____ Reason for surgery:_____
Date of surgery:_____ Reason for surgery:_____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis?	Yes	No
Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any cancer, radiation, or chemotherapy? Yes No
Describe: _____Date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: _____

SHAPIRO FAMILY DENTISTRY
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Patient's Name _____ Date of Birth _____/_____/_____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes?	Yes	No	Relationship _____	Cancer?	Yes	No	Relationship _____
Heart disease?	Yes	No	Relationship _____	Bleeding problems?	Yes	No	Relationship _____
Tumors?	Yes	No	Relationship _____	Lung disease?	Yes	No	Relationship _____
Sleep Apnea?	Yes	No	Relationship _____				

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Prescription pain medication?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No	Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. _____ _____	Yes	No

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug or food allergies not listed above: _____

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Patient's Name _____ Date of Birth _____/_____/_____

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? If yes, for how long? _____
Yes No

Have you ever sought professional care or been hospitalized for:			**Do you use:**			
Substance abuse?	Yes	No	Alcohol?	Yes	No	How often? _____
Emotional disorders?	Yes	No	Marijuana?	Yes	No	How often? _____
Alcoholism?	Yes	No	Recreational drugs?	Yes	No	How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?_____

_____

_____

_____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.

_____ _____
Signature of patient, parent, guardian Date

_____ _____
Printed name of patient, parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____

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Financial Policy

This financial policy contains important information about billing and payment for our professional services. It outlines your responsibility as the patient and our responsibility concerning billing and payment for our services.

- ✓ Our practice participates with many health insurance companies. Our business office will submit the claim for any services rendered to a patient who is a member of one of these plans. It is the patient's responsibility to provide us with current insurance information and to confirm that our Dentists are participating in their insurance plan at time of service. **The burden of proof is the patient's responsibility and not the Dentist responsibility.**
- ✓ If patient is a member of an insurance plan with out-of- network benefits in which we do not participate, our office will also file the claim on the patient's behalf; however**, the patient is expected to make payment in full at time of service**.
- ✓ It is the patient responsibility to make payment at time of service for co-payment or deductible. Any services not covered by patient's insurance plan are the patient's responsibility and payment in full is expected at time of service.
- ✓ It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided prior to the visit. In the absence of a required authorization or referral, the patient's visit may be rescheduled, or the patient may be personally responsible for payment for the services rendered by Our office.
- ✓ If you request the completion of medical forms or special letters from the Dentist, we may be charged at least $25.00 per form/letter for duplication.
- ✓ **Please, understand that when you do not cancel an appointment you are unable to keep, it may prevent other patients from receiving the care they need. Therefore, our office may charge a fee of $25.00 for appointments not cancelled with 48 hours' notice.**
- ✓ Payment for professional services can be made by cash, credit card, debit card, or through special third-party financing with Care Credit (subject to credit approval).
- ✓ Major procedures may require a reservation fee up to $100 to secure a specialty appointment which may be non-refundable if appointment is canceled or changed without 48-hour notice. This reservation fee will be applied to your dental treatment received.
- ✓ **Insurance**: We are happy to bill both primary insurance out of courtesy for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portion do; however, if the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment would be expected within 30 days of receiving a statement.
- ✓ **Patient Payment**: The patient portion due for services rendered is expected at the time of service unless previous arrangements have been made. We except cash, checks and all major credit cards.
- ✓ **Financing**: We have financing options available through Care Credit. If you have an interest in this option, please consult with the office manager prior to the date of the schedule treatment.
- ✓ **No-shows/missed appointments**: We request notice to cancel or reschedule appointment of at least 48 hours (two business days) prior to the appointment as scheduled. If appropriate notice is not given, a charge of $25 per hour of scheduled appointment will be assessed of the patient's account (example: 1 hour or less appointment = $25 charge, 2 hr appointment = $50 charge, etc.)
- ✓ **Refunds for Unfinished Treatment**: If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or dentist.
- ✓ **Credits on an Account**: If insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.
- ✓ **Collections**: On occasion, after repeated attempts to collect the balance due, we may need to turn in account over to a collection agency. Should this occur, it was agreed the financially responsible party pays all finance charges, collection cost, attorney's fees, and any other costs that may be incurred to enforce collection of any amount outstanding.

Signature of Patient/Guardian	Name of Patient/Guardian	Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures me may make of your protected health information. A copy of this Notice accompanies this Consent for you to take with you. 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 which will contain the changes. These changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practice including any revision at any time by contacting us by phone or by mail at the above address.

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 revocation of this Consent will not affect any action we took in reliance on the Consent prior to receipt of you revocation and that we may decline to treat you or continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your 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 health care operations.

I have read, understand, and agree to the Financial Policy and Disclosure of Health Information. I understand a billing representative is available to me if I have any questions. I also acknowledge receipt of Shapiro Family Dentistry Notice of Privacy Practices.

_____	_____	_____
Signature of Patient/Guardian	**Name of Patient/Guardian**	**Date**

AFTER THE EXAMINATION, A TREATMENT PLAN WILL BE EXPLAINED TO ME WHICH WILL ESTIMATE WHAT MY INSURANCE SHOULD PAY AND WHAT MY COPAYMENT WILL BE AT TIME OF TREATMENT, AND I AGREE TO PAY FOR ANY DENTAL SERVICES PROVIDED BY SHAPIRO FAMILY DENTISTRY THAT MY INSURANCE COMPANY FAILS TO PAY.

_____ **Initial of Patient/Guardian**

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