PATIENT INFORMATION

Please present your driver's license and insurance card to the receptionist to be photocopied.

Last Name____ First Name__________________________ Middle Initial_____

Address____ City______________________ State______ Zip____________

Home Phone_____________________ Work Phone______________________ Cell Phone_______________________

E-Mail Address____ May we contact you by e-mail? (circle) **Yes No**

Social Security Number___________________________ Date of Birth_______________ Gender (circle) **Male Female**

Employer____ Occupation____________________________________

Marital Status ☐ **Single** ☐ **Married** ☐ **Child** ☐ **Other** _________________ Spouse's Name______________________

Emergency Contact___________________________________ Phone Number_________________________________

How did you hear about us? ____

DENTAL QUESTIONNAIRE

When was your last cleaning?____________________ Exam?____________________ X-rays?____________________

What is the name of your previous dentist?____

Are you experiencing any of the following problems at this time?

☐ **Pain/Sensitivity** ☐ **Bleeding Gums** ☐ **Teeth Grinding** ☐ **Other**________________________________

Would you change any of the following regarding the appearance of your teeth?

☐ **Color/Shade** ☐ **Shape/Size** ☐ **Crowding/Spacing** ☐ **Other**_____________________________________

INSURANCE INFORMATION

Do you have dental insurance? (circle) **Yes No** Do you have secondary dental insurance? (circle) **Yes No**

Primary Insurance		**Secondary Insurance**	
Subscriber Name		Subscriber Name	
Subscriber SSN/ID#		Subscriber SSN/ID#	
Employer Name		Employer Name	
Insurance Company		Insurance Company	

Patient/Parent/Guardian Signature____ **Today's Date**______________

PATIENT MEDICAL HISTORY

Your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following questions to the best of your knowledge.

Patient Name____ Date of Birth_____________

Are you currently under the care of a physician? (circle) **Yes No** If yes, for what?____________________________

Physician's Name____ Physician's Phone_________________________

Please provide the name and dosage of the medication(s) you are currently taking_____________________________

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Do you take aspirin daily? (circle) **Yes No** If yes, how many?____

Have you been hospitalized in the last 5 years? (circle) **Yes No** If yes, for what?__________________________

Do you use tobacco? (circle) **Yes No**

Women, are you pregnant? (circle) **Yes No** Taking oral contraceptives? (circle) **Yes No** Nursing? (circle) **Yes No**

Are you allergic to any of the following? ☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Local Anesthetics** ☐ **Acrylic**

☐ **Metal** ☐ **Latex** ☐ **Sulfa Drugs** ☐ **Other**______________________

Do you have, or have you had, any of the following? (circle)					
Anemia	**Yes No**	Epilepsy or Seizures	**Yes No**	Lung Disease	**Yes No**
Arthritis	**Yes No**	Excessive Bleeding	**Yes No**	Mitral Valve Prolapse	**Yes No**
Artificial Joint/Prosthesis	**Yes No**	Fainting/Dizzy Spells	**Yes No**	Pace Maker/Heart Surgery	**Yes No**
Aspirin/Anticoagulant Therapy	**Yes No**	Head/Neck Injury	**Yes No**	Psychiatric Treatment	**Yes No**
Asthma	**Yes No**	Heart Murmur	**Yes No**	Rheumatic Fever	**Yes No**
Blood Disease	**Yes No**	Heart Surgery/Disease	**Yes No**	Sinus Problems	**Yes No**
Blood Transfusion	**Yes No**	Hemophilia	**Yes No**	Stroke	**Yes No**
Breathing Problems	**Yes No**	Hepatitis (Type_____)	**Yes No**	Thyroid Disease	**Yes No**
Cancer	**Yes No**	High Blood Pressure	**Yes No**	Tuberculosis (TB)	**Yes No**
Chemotherapy	**Yes No**	HIV Positive/AIDS	**Yes No**	Ulcers/Stomach Problems	**Yes No**
Diabetes	**Yes No**	Kidney Disease	**Yes No**	Venereal Disease	**Yes No**
Dialysis	**Yes No**	Liver Disease	**Yes No**	Other	**Yes No**
Ear/Eye Trouble	**Yes No**	Low Blood Pressure	**Yes No**		**Yes No**

Patient/Parent/Guardian Signature____ **Today's Date**_____________

PATIENT ACKNOWLEDGEMENT

CANCELLATION POLICY

__________ Initials

We kindly ask that you give us at least 24 hours notice if you must change an appointment. This courtesy makes it possible to give your reserved time to another patient who would like it. A $25 fee may be applied to your account for cancellations made less than 24 hours of your appointment time.

FINANCIAL POLICY

Our primary mission at Shelby Family Dental Care is to deliver the best dental care available at a reasonable cost.

Unless other arrangements have been made in advance, your payment is due on the day that services are rendered. For your convenience, we accept cash, check, Visa, MasterCard, and Discover. We also provide interest-free financing options with CareCredit.

Our staff is dedicated to providing you with the most accurate co-payment information based on your insurance coverage. Please be aware that your insurance only estimates coverage and, therefore, any amount not covered by your insurance is your responsibility.

__________ Initials

Accounts which are 90 days or more past due may be subject to a 1.5% interest charge and/or collection action.

ASSIGNMENT OF BENEFITS

__________ Initials

Our office will send claims to your insurance carrier(s) on your behalf and accept reimbursement for the services rendered. By acknowledging this assignment of benefits, you authorize insurance payments to be made directly to Shelby Family Dental Care.

NOTICE OF PRIVACY PRACTICES

The notice of privacy practices is located in the patient lobby. Please take a copy for your reference.

__________ Initials

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to supply you with the Notice of Privacy Practices which explains how we may use and disclose information about you for treatment, payment, and healthcare operations. By initialing, you acknowledge that you are aware of our privacy practices and have had the opportunity to ask questions regarding your personal privacy.

I have read and understand Shelby Family Dental Care's Cancellation Policy, Financial Policy, Assignment of Benefits, and Notice of Privacy Practices.

Patient Name (Please Print)____

Patient/Parent/Guardian Signature____ **Today's Date**_____________