shinedental – patient information

TODAY'S DATE ________________

PATIENT'S NAME: ______________________________

MALE ☐ FEMALE ☐

DATE OF BIRTH ________________________________

PARENT'S NAME (if child): ______________________

HOW DO YOU WISH TO BE ADDRESSED: ____________

SINGLE ☐ MARRIED ☐ SEPARATED ☐
DIVORCED ☐ WIDOWED ☐ MINOR ☐

HOME ADDRESS ________________________________

CITY ____________________ POSTAL __________

PHONE # HOME - ____________ CELL - ____________

EMAIL ADDRESS - ______________________________
(please include as important notices and appointment reminders are sent via email)

PLACE OF WORK - ______________________________
WORK ADDRESS - ______________________________
ARE YOU A FT/PT COLLEGE STUDENT? ______________
- IF YES, WHERE? ____________________________

METHOD OF PAYMENT:
DEBIT ☐ CREDIT ☐ CASH ☐ CHEQUE ☐

HOW DID YOU HEAR ABOUT US: **CHECK ALL THAT APPLY.**
- ☐ WEBSITE
- ☐ I SEARCH ONLINE
- ☐ I RECEIVED AN AD IN THE MAIL
- ☐ I HEARD YOU ON THE RADIO STATION ____________
- ☐ I SAW YOUR AD IN THE NEWSPAPER
- ☐ I DROVE BY
- ☐ I WAS REFERRED BY ____________
- ☐ YELLOW PAGES
- ☐ BILLBOARD
- ☐ OTHER: ____________

REASON FOR THIS VISIT ________________________
DATE OF LAST DENTAL VISIT____________________
OTHER IMMEDIATE FAMILY MEMBERS WHO ARE PATIENTS HERE ______________________________

DENTAL INSURANCE – FIRST COVERAGE

EMPLOYEE NAME ________________________ SAME ☐
EMPLOYEE DATE OF BIRTH ________________ SAME ☐
EMPLOYER ____________________________________
BUSINESS ADDRESS ____________________________
BUSINESS PHONE ____________ POSTAL __________
OCCUPATION _________________________________
NAME OF INSURANCE COMPANY __________________
POLICY/GROUP# _______________________________
CERTIFICATE/ID/CONTRACT# ____________________

DENTAL INSURANCE – SECONDARY COVERAGE

EMPLOYEE NAME _______________________________
EMPLOYEE DATE OF BIRTH ______________________
EMPLOYER ____________________________________
BUSINESS ADDRESS ____________________________
BUSINESS PHONE ____________ POSTAL __________
OCCUPATION _________________________________
NAME OF INSURANCE COMPANY __________________
POLICY/GROUP# _______________________________
CERTIFICATE/ID/CONTRACT# ____________________

IN CASE OF AN EMERGENCY PLEASE CALL

____________________ **AT** ____________________

RELEASE

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dental specialist or health care provider, only if deemed necessary for the beneficial health care of the patient.

CONSENT

- This practice DOES NOT ACCEPT ASSIGNMENT OF BENEFITS and therefore depends upon reimbursement at the time of service from the patients for the costs incurred in their care.
- Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms (and email claims) in order to assist the patient in collecting benefits from their insurance company.
- I understand that any payment plan agreement for dental care can only be extended for a period of 3 months from the date it was prepared and a fee estimate is valid for the fiscal year in which it was prepared as fees are updated on a yearly basis.

I have read the above conditions of release and consent and agree to their content AND attest to the accuracy of the information provided on this page:

PATIENT'S OR GUARDIAN'S SIGNATURE ______________________________ **DATE** ____________________

PLEASE TURN OVER TO COMPLETE MEDICAL HISTORY

shinedental - medical history

patient's name: ____

last first initial date of birth

Please circle the appropriate answer.
If you don't know the correct answer please write "don't know" on the line after the question.

1. Physician's name ______________________
   Address ______________________
   When was your last visit? ______________________
2. Are you taking any medication or substances? .... yes no
   (if yes please list medications in the lines provided at the bottom of page)
3. Are you allergic to any medication or substances? .... yes no
   If yes, please list: ______________________
4. Do you have any problems or allergies with penicillin or antibiotics?.............. yes no
5. Do you have any problems with anesthetics or any other medications?.......... yes no
6. Are you sensitive to metals? .... yes no
7. Are you sensitive to latex? .... yes no
8. Are you pregnant or suspect you may be?.. yes no
9. Do you use any birth control medications? .... yes no
10. Have you been told you have heart disease or had a recent heart attack?....... yes no
11. Do you have a pacemaker or an artificial heart valve implant?...................... yes no
12. Have you ever had rheumatic fever? .... yes no
13. Are you aware of any heart murmurs? .... yes no
14. Do you have high or low blood pressure? .... yes no
    If YES, plese indicate which one ______________________
15. Have you ever had a serious illness or major surgery?............................... yes no
    If YES, explain ______________________
16. Have you ever had radiation or chemotherapy treatment? .... yes no
17. Do you have inflammatory diseases, such as arthritis or rheumatism?........... yes no
18. Do you have any artificial joints/prosthesis? .... yes no
19. Do you have any blood disorders, such as anemia, leukemia, etc.?............... yes no
20. Have you ever bled excessively after being cut or injured?........................... yes no
21. Are you diabetic? .... yes no
    If YES, how are you controlling it? ______________________
22. Do you have asthma? .... yes no
23. Do you have epilepsy or seizure disorders?... yes no
24. Have you ever tested HIV positive? .... yes no
25. Have you ever tested positive for hepatitis? .... yes no
26. Do you or have you ever had T.B.?.. yes no
27. Do you require prophylactic antibiotics before dental appointments?............. yes no
28. Do you take bis-phosphonates?.. yes no
29. Do you have active bone disease, histocytosisX, multiple myeloma or Paget's? yes no
30. Have you ever smoked, chewed, used snuff or any other form of tobacco? yes no
    Number of years of used?__________ Number of years quit?__________
31. Is there anything else we should know about your health that we have not covered in this form? ______________________ yes no
32. Would you like to speak to the doctor privately about any problem? yes no

Please list any medications/substances you are currently taking on the lines provided below:

____

____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT/GUARDIAN'S SIGNATURE: ______________________ DATE: __________

DENTIST'S SIGNATURE: ______________________ DATE: __________