Shawnee Family Dental

Patient Information

Date: _____ **Social Security#:** _____

Patient Last Name:_____

Patient First Name:_____

Address:_____

City: _____ **State:** _____

Zip Code: _____ **Sex:** o Male o Female

Birthday: _____ **Age:** _____

___ Married ___ Single ___ Divorced ___ Minor ___Other

Email:_____

Employer/School: _____

Occupation: _____

Employer/School Address:

_____

_____

Employer/School Phone: _____

Spouse's Name: _____

Birthday:_____ **SS#:**_____

Spouse's Employer:_____

Whom may we thank for referring you?_____

Insurance Information

Who is responsible for this account? _____

Insurance Company:_____

Subscribers' Name:_____

Group Number:_____ **SS#:**_____

Date of Birth:_____

Is patient covered by additional insurance? ____ Yes ____No

Insurance Company:_____

Subscribers' Name:_____

Group Number:_____ **SS#:**_____

Date of Birth:_____

Assignment and Release

I certify that I and/or my dependent(s), have insurance coverage with the company listed herein, and I assign directly to Shawnee Family Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Shawnee Family Dental may use my health care information and may disclose such information to my insurance companies named herein and their agents for the purpose of obtaining payment for the services and determining insurance benefits or the benefits payable for related services.

_____ _____

Please Print Name Please Sign Name

_____ _____

Date Relationship to Patient

Phone Numbers: **Home/Cell Phone:** _____-_____-_____ **Work Phone:** _____-_____-_____

Emergency Contact: **Name:** _____ **Relationship:**_____

Phone: _____-_____-_____ **When's the best time to reach you?**_____

Dental History: **Reason for today's visit:** _____ **Former Dentist:** _____

Date of last dental visit: _____ **Date of last dental X-rays:** _____

Bad Breathe	O Yes O No	Jaw Pain	O Yes O No	Sensitivity to sweets	O Yes O No
Bleeding Gums	O Yes O No	Lip/cheek biting	O Yes O No	Sensitivity to biting	O Yes O No
Blisters on lips or mouth	O Yes O No	Loose teeth	O Yes O No	Smoking Cigarette/Pipe	O Yes O No
Burning sensation on tongue	O Yes O No	Mouth Breathing	O Yes O No	Sores in your mouth	O Yes O No
Chew on one side	O Yes O No	Mouth Pain	O Yes O No	How often do you floss?	
Clicking or popping jaw	O Yes O No	Ortho Treatment /Braces	O Yes O No	_____	
Dry mouth	O Yes O No	Pain around Ear	O Yes O No		
Fingernail biting	O Yes O No	Periodontal/Gum Treatment	O Yes O No	How often do you brush?	
Food collection b/t teeth	O Yes O No	Sensitivity to cold	O Yes O No	_____	
Grinding teeth	O Yes O No	Sensitivity to heat	O Yes O No		

Shawnee Family Dental

Health History

Family Physician's Name: _____ Date of last visit: _____

Have you ever used a bisphosphonate medication? O Yes O No

(Common brand names are Fosamax, Actonel, Atelvia, Didronel or Boniva)

Have you ever taken any of the group drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brad names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). O Yes O No

Please mark "X" if you have any of the following conditions:

AIDS/HIV	O Yes O No	Epilepsy	O Yes O No	Rheumatic Fever	O Yes O No
Anemia	O Yes O No	Fainting	O Yes O No	Scarlet Fever	O Yes O No
Arthritis	O Yes O No	Glaucoma	O Yes O No	Shortness Of Breath	O Yes O No
Artificial Heart Valves	O Yes O No	Heart Murmur	O Yes O No	Sinus Trouble	O Yes O No
Artificial Joints	O Yes O No	Heart Problems	O Yes O No	Skin Rash	O Yes O No
Asthma	O Yes O No	Hepatitis Type	O Yes O No	Special Diet	O Yes O No
Autism	O Yes O No	Herpes	O Yes O No	Stroke	O Yes O No
Back Problems	O Yes O No	High Blood Pressure	O Yes O No	Swollen Feet/Ankles	O Yes O No
Bleeding abnormally	O Yes O No	Jaundice	O Yes O No	Swollen Neck Glands	O Yes O No
Blood Disease	O Yes O No	Jaw Pain	O Yes O No	Thyroid Problems	O Yes O No
Cancer	O Yes O No	Kidney Disease	O Yes O No	Tonsillitis	O Yes O No
Chemical Dependency	O Yes O No	Liver Pain	O Yes O No	Tuberculosis	O Yes O No
Chemotherapy	O Yes O No	Low Blood Pressure	O Yes O No	Tumor or Growth	O Yes O No
Circulatory Problems	O Yes O No	Mitral Valve Prolapse	O Yes O No	Ulcer	O Yes O No
Congenital Health Lesions	O Yes O No	Alzheimer's/Dementia	O Yes O No	Venereal Disease	O Yes O No
Cortisone Treatments	O Yes O No	Nervous Problems	O Yes O No	Weight Loss	O Yes O No
Cough, persistent/bloody	O Yes O No	Pacemaker	O Yes O No	Are you pregnant?	O Yes O No
Diabetes	O Yes O No	Psychiatric Care/Mental Illness	O Yes O No	Taking birth control pills?	O Yes O No

Medications

List or supply a copy of any medications you are currently taking:

_____

_____

_____

_____

_____

_____

Pharmacy Name: _____

Allergies

- **O Aspirin**
- **O Barbiturates (sleeping pills)**
- **O Codeine**
- **O Iodine**
- **O Latex**
- **O Local Anesthetic**
- **O Penicillin**
- **O Sulfa**
- **O Other:** _____

_____

_____

Shawnee Family Dental

I _____ hereby agree on this date _____
Print Patients Full Name **Today's Date**

to allow the doctors and staff of Shawnee Family Dental to treat me for any and all necessary dental concerns that may be present now or in the future, including but not limited to:

periodontal treatment (gums), prophylaxis (cleaning & exam), restorative dentistry (fillings), endodontics (root canals & pulp treatments), prosthodontics (dentures & partials), sealants (coatings on teeth), bleaching (whitening), bonding & veneers (cosmetic dentistry), Invisalign (clear braces), Nitrous Oxide (laughing gas), local anesthetic (lidocaine injection), exodontia (tooth extraction), TMJ/TMD dysfunction (jaw joint pain), radiographs (x-rays) and other general dental care.

I realize I will have the opportunity to decline treatment at any time.

I have read the statement above and hereby consent to treatment <u>when and if the doctors or staff inform me that it is needed</u>, by signing this form below. In addition, I understand that by keeping the appointment scheduled for any procedure listed or unlisted that I am giving my consent for treatment.

_____ _____
Patients Signature **Today's Date**

If the patient is a child or young adult under the age of 18 please sign below.

_____ _____
Parents Signature or Guardian **Today's Date**

Financial Policy

<u>Our Commitment</u>

Shawnee Family Dental

Shawnee Family Dental is committed to the highest quality dental care possible, offering affordable services with maximum payment flexibility. Before treatment is undertaken we will consult with you so that you fully understand the need, the procedures, and the expense of your dental treatment. Together, we will implement the best plan for your dental care. In order to achieve this, we need your understanding of our payment policy.

Payment Options

Payment is due at the time services are rendered unless other arrangements have been made in advance. In all cases, payment in full is required at treatment completion. For your convenience, we offer the following options:

- **5% Cash or Check Discount**
  Patients who pay their entire bill by cash or check at the time services are rendered (whether they have dental insurance or not) will receive a 5% reward. We will assist patients with dental insurance by filing their claim and we will instruct the insurance company to reimburse the patient directly.

- **VISA, Master Card, Discover or American Express**
- **Dental Insurance**
  It is important to understand our relationship is with you, not your insurance company. Additionally, our fees are the same for all patients regardless of their insurance coverage. We will present a treatment plan and an estimate of expenses, if needed, after the patient examination. Estimates are based upon available insurance information and do not guarantee payment by your insurance company. We will bill your insurance company as a courtesy; however, co-payments and deductibles are due at the time of service. Patients with dual insurance should know that they are not guaranteed 100% coverage. Fees not covered by insurance are the patient's responsibility.

- **Care credit Financing Option**
  Care credit is a nationally recognized credit provider that specializes in assisting individuals with financing for their dental care. Care credit provides patients with interest free payment plans as well as extended payment plans for patients who prefer more time to pay. Patients may be approved for Care credit within a couple of minutes at our office. More information about using Care credit may be obtained from the staff. In all cases, approval for Care credit should be arranged prior to treatment

Senior Reward

We are pleased to extend a 5% discount to our senior patients (62 years and older) regardless of payment method. Please note that this cannot be combined with the cash discount.

New Patient Emergency Appointments

We request payment at the time of service for new patient emergency procedures. We will accept cash, personal checks and money orders for new patient emergency appointments.

Broken Appointment Policy

We anticipate that all patients will keep their scheduled appointments and we will make a reasonable effort to help them do so. However, situations do arise which may cause a patient to reschedule. We will gladly reschedule appointments, but we require 24 hours advance notice. Patients who fail to attend their appointments and have not provided us with 24 hours advance notice will be charged a $50 broken appointment fee. In addition, patients who arrive late for their scheduled appointment time may have to forfeit their appointment and may be subject to the broken appointment fee.

Acceptance of Terms

I have read and fully understand the above financial policies and agree to the terms outlined herein.

_____ _____ _____

Date (Signature of Patient or Guardian) Signature of Patient

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

Shawnee Family Dental

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

_____

Agreement to received electronic communications

Shawnee Family Dental

Patient Name: _____

Date of Birth:_____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

[419-225-4751].

Email Address (PLEASE PRINT CLEARLY):

_____@_____. _____

Patient Signature:_____

Date:_____