SHALIMAR
FAMILY DENTISTRY

Patient Name:_____ **Patient Date of Birth:**_____

Are you aware of the link between the bacteria in your mouth and your overall health?		
Dental History	**Yes**	**No**
Are your teeth sensitive to (circle which apply):		
Heat Cold Sweets Pressure		
If yes, please explain:		
Does food catch between your teeth?		
If yes, please state location:		
Do your gums bleed when brushing or flossing?		
Do you feel you have bad breath?		
Have you ever had a "deep cleaning" (below your gums and usually requiring anesthetic)?		
Do you have problems with your jaw joint (TMJ)?		
Clicking?		
Jaw Pain (Joints, ear side of face)?		
Difficulty chewing?		
Locking open or closed?		
Headaches when awakening?		
Have you ever had an adverse reaction to anesthetics?		
If yes, please describe:		
Do you currently or have you ever used tobacco products?		
If yes, please circle:		
cigarettes chewing tobacco vaping e-cigarettes smoking marijuana		
When was your last oral cancer screening?		
Do you have any lumps, bumps or sores in our mouth that have not healed within 10 days?		
If yes, please state location:		
Do you have missing teeth?		
If so, how long have they been missing?		years
Rate your smile on a scale of 1-10		
What would make your smile a 10?		
When was your last dental appointment?		
When was your last dental cleaning?		
Have you ever had orthodontic treatment?		
Rate your anxiety you have about dental treatment 1-10		
Are you interested in learning more about sedation options for dental care?		
What is your chief dental concern?		

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Health History	Yes	No	Date Diagnosed
Are you under a physician's care at this time?			
If yes, please explain and list the name and phone number for your MD.			
Have you ever been treated for a bone disorder (i.e. osteoporosis)?			
Have you ever been treated for any kind of cancer?			
If so, have you ever received radiation and/or chemotherapy?			
Do you have any conditions that require pre-medication?			
If yes, please explain.			
Do you take blood thinners?			
Do you have or have you ever had:			
Respiratory conditions, including asthma?			
Thyroid problems?			
Epilepsy?			
Stroke?			
High or low blood pressure?			
Pacemaker?			
Heart disease?			
Heart attack?			
Acid Reflux?			
STDs?			
Hepatitis (Please circle) A B C			
HPV?			
HIV/AIDS?			
Do you get cold sores?			
Have you ever been told, or notice, that you snore at night?			
Are you tired, fatigued or sleepy on most days?			
Drug Allergies? Please list:			
Are you diabetic? If yes, please circle: Type l or type II			
Is your diabetes well controlled?			
Do you have a sugar source with you at all times?			
Did you know there is a direct link between diabetes and gum disease?			
Women: Are you pregnant?			
Are you nursing?			
Are you taking birth control pills?			
Please list all medications you are taking including over the counter medications:			
By signing below, you acknowledge you have provided an accurate health history to your dental office. Please keep your dental team informed of any changes in your health as changes can affect your oral health. Additionally, many diseases present in the oral cavity and you may be asked to see your medical doctor for diagnosis.			

_____ _____

Signature of patient or Legal Guardian of patient Date

_____ _____

Patient Printed Name Printed Name of Guardian

_____ To be taken by Health Care Professional:

Provider Reviewed and Date

Initial BP: _____ and HR_____

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Who may we thank for referring you to our office? _____ Today's Date_____

Patient Information

Patient Information

Patient Name: _____ Preferred Name: _____ Date of Birth:_____ Gender: M/F

Mailing Address: _____City: _____State:_____ Zip:_____ SS#:_____

Home Phone: _____Work Phone: _____Cell:_____ Marital Status: _____

E-Mail:_____@_____ Employer:_____ Occupation:_____

Employer Address:_____ Employer Phone: _____

Emergency contact: _____Relationship:_____ Phone: _____ Phone: _____

Primary Insurance Information

Subscriber's Name: _____Date of Birth:_____ Employer: _____

SS#: _____ ID #_____ Name of Insurance Company: _____

Insurance Address: _____City: _____St:_____ Zip:_____ Phone:_____

Secondary Insurance Information

Subscriber's Name: _____Date of Birth:_____ Employer: _____

SS#: _____ ID #_____ Name of Insurance Company: _____

Insurance Address: _____City: _____St:_____ Zip:_____ Phone:_____

Would you like email and text message reminders? Email Y/N Text Y/N

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

HIPAA.

I acknowledge that I have been offered a copy of the Shalimar Family Dentistry Notice of Privacy Practices, containing a complete description of the uses and disclosures of my health information. This is simply an acknowledgement of receipt, and nothing more.

Patient Name:_____ Signature:_____

Relationship to Patient:_____ Date: _____

SHALIMAR
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OFFICE POLICY

Welcome to Shalimar Family Dentistry! Our interest is to provide our patients with the finest possible dental care. As your provider, we advise treatment that is in the best interest of your medical and dental health. Be aware, often, insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs. Following is an overview of our office financial policy we provide to you as a courtesy.

Insurance: Dental Insurance rarely pays for 100% of all dental services. ***As a courtesy***, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement.
Initials_____
Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays. Initials_____

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Initials_____

Payment: Payment in full is required at the time of service. For your convenience, we accept cash, checks, debit, and credit cards, including Visa, MasterCard, Discover, and American Express. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through Care Credit. Initials _____

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed as necessary. Initials_____

Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in Shalimar Family Dentistry being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees and court costs.
Initials____
Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with 48 hours notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of $50.00 per hour. Initials_____

Assignment of Benefit: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Shalimar Family Dentistry.

I have read, understand, and agree to the above.

_____
Signature of Person Responsible for Account

_____ _____
Printed Name of Person Responsible for Account Date