Dental History

Are you in dental discomfort? _____________________________

Reason for visit today _____________________________

Date of last dental care ___/___/_____ Date of last X-ray ___/___/_____

Former dentist ________________________

Have you had any unfavorable dental experiences? _________________________

Check if you have had problems with any of the following:

__ Bad Breath   __ Food collection between teeth   __ Periodontal treatment
__ Bleeding gums   __ Grinding or clenching teeth   __ Sensitivity to cold
__ Clicking or popping jaw   __ Loose teeth or broken fillings   __ Sensitivity to hot
__ Sensitivity to sweets   __ Sensitivity when biting   __ Sores or growths in mouth

How often do you brush? ____________________________

How often do you floss? ____________________________

Have you ever had instruction on the correct method of brushing teeth? __ Yes __ No

Have you ever had instruction on the care of your gums? __ Yes __ No

How do you feel about the appearance of your teeth and smile?
____________________________________________________________________

What would you like to change? _____________________________
Welcome!

We are pleased to welcome you to our practice.
How did you hear about us? Please circle:
YELP GOOGLE FACEBOOK DRIVE-BY OTHER:__________
Relative/Friend/Doctor:______________________________________

Patient Information
Name_________________________________________ Today’s Date ___/___/_____
Address ______________________________________ Birthdate ___/___/_____
City ___________ State ____ Zip _______ ___Male ___Female _____Child

Home phone ___________ Cell phone ___________ Work phone ___________
SS# - - - - - - - - - - - - - Email ____________

Employer (skip if child)_________________________ Occupation___________ # yrs
Business address ________________________________________________________

Notify in case of emergency __________________________ Day phone #___________

Spouse Information
Name_________________________________________ Birthdate ___/___/_____
Employer____________________________ Work phone ____________
SS# - - - - - - - - - - - - - - - - - - - - Cell phone ____________

Responsible Party/Primary Insurance Coverage
Name_____________________________ Relationship to patient _______________
SS# __- - - - - - - - - - - - - Address (if different) ___________________________
Home phone ___________ Cell phone ___________ Email _____________________
Employed by __________________________ Occupation___________ # yrs _
Business address ________________________________
Insurance Carrier ________________________________
Policy #__________________________ Group # _______

Secondary Insurance Coverage
Name_____________________________ Relationship to patient _______________
SS# __- - - - - - - - - - - - - Address (if different) ___________________________
Home phone ___________ Cell phone ___________ Email _____________________
Employed by __________________________ Occupation___________ # yrs _
Business address ________________________________
Insurance Carrier ________________________________
Policy #__________________________ Group # _______
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Shenk Dental Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Shenk Dental Care’s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent and receive a copy if I so desire. Shenk Dental Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice may be obtained by forwarding a written request to Shenk Dental Care at the office location.

With this consent, Dr. Shenk’s office may call my home, office or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dr. Shenk’s office may mail or email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, insurance forms or information, and patient statements. I have the right to request Dr. Shenk’s office to restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this.

By signing this form, I am consenting to Dr. Shenk’s use and disclosure of my PHI to carry out TPO, I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, I understand that I will be financially responsible for any dental work provided by this office.

______________________________
Print Patient’s Name

______________________________   ________________________________
Signature of Patient or legal Guardian  Print Name of legal Guardian

FOR OFFICE USE ONLY

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my PHI for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my consent: ______________________________

Signature________________________  Date________________________
Medical History

LIST ALL MEDICATIONS/DRUGS YOU ARE NOW TAKING:

__________________________________________

Do you take or have you ever taken:

Actonel (risedronate sodium), Fosamax (alendronate), or Boniva (ibandronate) circle if yes

Dosage and frequency: Start Date: Stop Date:

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?

Please check all that apply:

☐ Aspirin  ☐ Demerol  ☐ Erythromycin  ☐ Penicillin  ☐ Valium  ☐ Percodan
☐ Codeine  ☐ Latex  ☐ Tetracycline  ☐ Other Antibiotics  ☐ Darvon  ☐ Local Anesthetic
☐ Bananas  ☐ Chestnuts  ☐ Avocados  ☐ Kiwis

Allergy to any other medication or substance?  Yes  No  If Yes, please list:

Please mark YES or NO if you have had or you currently have...

Yes No

HEART DISEASE
☐  ☐ Congestive Heart Failure
☐  ☐ Heart Attack
☐  ☐ Chest Pains
☐  ☐ High Blood Pressure
☐  ☐ Murmur/Valve Disorder
☐  ☐ Rheumatic Fever
☐  ☐ Mitral Valve Prolapse
☐  ☐ Pacemaker
☐  ☐ Heart Bypass
☐  ☐ Valve Replacement
☐  ☐ Irregular Heart Beat

LUNG DISEASE
☐  ☐ Asthma  ☐ Date Last Attack
☐  ☐ Emphysema  ☐ Packs per day
☐  ☐ Sleep Apnea
☐  ☐ Chronic Cough

ENDOCRINE DISEASE
☐  ☐ Diabetes
☐  ☐ Thyroid

INFECTION DISEASE
☐  ☐ HIV Positive
☐  ☐ AIDS

NEUROLOGIC DISEASE
☐  ☐ Fibromyalgia
☐  ☐ Arthritis
☐  ☐ Connective Tissue Disease
☐  ☐ Lupus
☐  ☐ Artificial Joints
☐  ☐ Osteoporosis
☐  ☐ Jaw Joint Pain/dysfunction

BLOOD/CLOTTING DISORDER
☐  ☐ Neuro Muscular
☐  ☐ Stroke
☐  ☐ Seizures, Epilepsy
☐  ☐ Migraine Headaches

OTHER
☐  ☐ Anticoagulant Drugs
☐  ☐ Aspirin Usage
☐  ☐ Sinus Problems
☐  ☐ Liver Disease
☐  ☐ Cancer/Tumor Treatment
☐  ☐ By Radiation
☐  ☐ By Chemotherapy
☐  ☐ Chewing/Dipping Tobacco
☐  ☐ # of years

WOMEN ONLY
☐  ☐ Birth Control Pills
☐  ☐ Pregnant
☐  ☐ Nursing

Antibiotics may interfere with the effectiveness of oral contraceptives. Consult your physician for advice regarding other methods of birth control.

Is there any health condition not listed above?  Yes  No.  If Yes, please list:

I have read, understand, and answered the questions above. I will not hold Dr. Shenk or any other member of his staff responsible for any errors or omissions that I have made in completion of this form. I authorize the release of all information my insurance company requests.

Signature of Patient ___________________________________________ Date _______________________________

(Parent or Guardian if Minor)
OFFICE POLICIES

FINANCIAL POLICY

Patients are expected to pay in cash, check, or credit card the day the service is rendered. For patients who are covered by insurance, we will accept assignment of benefits. Most dental insurance plans do not cover 100% of the cost of treatment. Because of this and the delay in receiving payment from the insurance company, we require that you pay your deductible and co-payment on the day the service is rendered. **We will estimate this amount as closely as possible using the insurance information we have; however, THIS IS AN ESTIMATE. Our agreement is with YOU and NOT your insurance company.** We will assist you in working with your insurance company, however the ultimate responsibility lies with you. After sixty (60) days, the balance will be due in full. I understand that a finance charge of 1.5% will be added to my account for charges due over sixty (60) days.

Signature __________________________________________  Date _________________________

LATE/MISSED APPOINTMENTS

At our office, we know that your time is valuable and we reserve a time slot just for you to give you the best service possible. For us to keep this level of service, we ask our patients to give us a minimum of 24 hours notice if they can’t make it to their appointment. This allows for patients with an emergency to be scheduled into that time. **Please note that patients may be subject to a $75 fee for failed appointments and appointments cancelled without 24 hours’ notice.** **Prescheduled treatment appointments that are not cancelled within these guidelines may have a higher fee depending on the type of service that was scheduled.**

Signature __________________________________________  Date _________________________
Patient Consent
Dental Treatment in the Era of COVID-19

Patient Name:________________________________________

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as “coronavirus,” at any time or in any place. Be assured that we continue to follow state and federal regulations as well as recommended universal personal protective equipment (PPE) and disinfection protocols to limit transmission of all diseases in our office.

Despite our careful attention to sterilization, disinfection and the use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be exposed at your gym, grocery store or favorite restaurant. Nationwide social distancing has reduced the transmission of the coronavirus. Although we have taken measures to enable social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dental healthcare team members and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes_______    No________

__________________________________   ______________________________
Patient/Parent’s Signature     Date