770.992.6568
www.drshenk.com

SHENK DENTAL CARE

Judd W. Shenk, DMD

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? _____

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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_____ Birthdate ____/____/_____
SS#____-___-_____ Relationship to patient _____
Address (if different) _____
Home phone _____ Cell phone _____ Email _____
Employed by_____ Occupation_____# yrs _
Business address _____
Insurance Carrier_____
Policy #_____ Group # _____

Secondary Insurance Coverage
Name_____ Birthdate ____/____/_____
SS#____-___-_____ Relationship to patient _____
Address (if different) _____
Home phone _____ Cell phone _____ Email _____
Employed by_____ Occupation_____# yrs _
Business address _____
Insurance Carrier_____
Policy #_____ Group # _____

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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

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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_____

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SHENK DENTAL CARE

Judd W. Shenk, DMD

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		Yes	No		Yes	No	
		HEART DISEASE			Hepatitis A	☐	☐	Anticoagulant Drugs
☐	☐	Congestive Heart Failure	☐	☐	Hepatitis B	☐	☐	Aspirin Usage
☐	☐	Heart Attack	☐	☐	Hepatitis C			**OTHER**
☐	☐	Chest Pains	☐	☐	Tuberculosis	☐	☐	Sinus Problems
☐	☐	High Blood Pressure	☐	☐	Venereal	☐	☐	Liver Disease
☐	☐	Murmur/Valve Disorder	☐	☐	Other	☐	☐	Cancer/Tumor Treatment
☐	☐	Rheumatic Fever			**MUSCULO SKELETAL DISEASE**			___ By Radiation
☐	☐	Mitral Valve Prolapse	☐	☐	Fibromyalgia			___ By Chemotherapy
☐	☐	Pacemaker	☐	☐	Arthritis	☐	☐	Chewing/Dipping Tobacco
☐	☐	Heart Bypass	☐	☐	Connective Tissue Disease			# of years _____
☐	☐	Valve Replacement	☐	☐	Lupus	☐	☐	Taking Diet Pills
☐	☐	Irregular Heart Beat	☐	☐	Artificial Joints	☐	☐	Psychiatric Treatment
		LUNG DISEASE	☐	☐	Osteoporosis	☐	☐	Ulcers
☐	☐	Asthma	☐	☐	Jaw Joint Pain/dysfunction	☐	☐	Drug Addiction
		Date Last Attack_____			**NEUROLOGIC DISEASE**			**WOMEN ONLY**
☐	☐	Emphysema	☐	☐	Neuro Muscular	☐	☐	Birth Control Pills
☐	☐	Smoke Tobacco	☐	☐	Stroke	☐	☐	Pregnant
		# of years_____	☐	☐	Seizures, Epilepsy	☐	☐	Nursing
		Packs per day _____	☐	☐	Migraine Headaches			**Antibiotics may interfere with the effectiveness of oral contraceptives. Consult your physician for advice regarding other methods of birth control.**
☐	☐	Sleep Apnea			**BLOOD/CLOTTING DISORDER**			
☐	☐	Chronic Cough	☐	☐	Prolonged Bleeding			
		ENDOCRINE DISEASE	☐	☐	Anemia			
☐	☐	Diabetes	☐	☐	Hemophilia			
☐	☐	Thyroid	☐	☐	Platelet Disorder			
		INFECTIOUS DISEASE	☐	☐	Sickle Cell Disease			
☐	☐	HIV Positive	☐	☐	Bruising			
☐	☐	AIDS						

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

Name_____

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** _____