



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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding or clenching teeth | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> 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 _____ 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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Judd W. Shenk, DMD

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

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

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 POLICIES:

Shenk Dental Care IS NOT AN IN-NETWORK PROVIDER.

Patients are expected to pay their expected portion of the procedure on the date of service via check or credit card. For patients with current PPO dental insurance, we will file a claim on your behalf. Most dental insurance plans do not cover 100% of our cost of treatment. We will estimate your portion as closely as possible using the information provided by your insurance company. THIS IS AN ESTIMATE and does not constitute an exact amount. This agreement is with YOU and not your insurance company. After 60 days, the balance will be due in full. After 90 days, a finance charge of 1.5% will be applied to the remaining balance monthly. **INITIAL** _____

Patients with outstanding balances over 180 days will have any upcoming appointments cancelled. Those appointments can be rescheduled once the balance has been paid in full. **INITIAL** _____

MISSED APPOINTMENTS:

At our office, we appreciate your valuable time and reserve an adequate time slot just for you, to be able to provide you the best service. For us to keep this level of service, we ask our patients to give us a minimum of 24 hours to cancel any appointment.

Please note that late cancellations/no shows will be subject to a \$75 missed appointment fee. Patients who have cancelled the same appointment 2 times may be asked to pre-pay their expected portion before rescheduling. **INITIAL** _____

ELECTRONIC COMMUNICATION AGREEMENT:

Shenk Dental Care may communicate with me electronically using the email and/or mobile phone information on file. All account statements will be paperless and sent via email unless requested by mail only. I can withdraw this consent at any time by calling the office at 770-992-6568 **INITIAL** _____

EMAIL: _____ **CONTACT NUMBER:** _____

SIGNATURE: _____ **DATE:** _____