shine dental

NEW PATIENT FORM

TODAY'S DATE _____

FIRST NAME _____

LAST NAME _____

NICKNAME (OR NAME I GO BY) _____

DATE OF BIRTH _____ AGE _____

☐ MALE ☐ FEMALE

☐ SINGLE ☐ MARRIED ☐ SEPARATED

☐ DIVORCED ☐ WIDOWED ☐ MINOR

SPOUSE'S NAME _____

HOME ADDRESS _____

CITY _____ PROV._____ P.C _____

EMPLOYER _____

OCCUPATION _____

ARE YOU A FT/PT COLLEGE STUDENT? _____

• IF YES, WHERE? _____

EMERGENCY CONTACT: NAME _____

RELATIONSHIP TO YOU _____

BEST NUMBER TO REACH THEM: _____

MOBILE # _____ WORK #_____ HOME #_____

EMAIL ADDRESS _____

IF YOU'D LIKE TO OPT OUT OF EMAIL REMINDERS AND CORRESPONDENCE, CHECK THE BOX. ☐ OPT OUT

WHAT IS THE BEST WAY TO REACH YOU: ☐ EMAIL ☐ MOBILE ☐ WORK PHONE ☐ HOME PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ WEBSITE ☐ RADIO ☐ NEWSPAPER ☐ YELLOW PAGES ☐ RECEIVED AN AD IN THE MAIL ☐ I DROVE BY

☐ REFERRAL _____(NAME) ☐ OTHER _____

WHAT IS THE REASON FOR THIS VISIT?

☐ GENERAL DENTISTRY ☐ IMPLANT(S) ☐ ORTHODONTICS ☐ SLEEP ☐ AIRWAY ☐ PAIN ☐ OTHER _____

IN YOUR OWN WORDS, WHAT IS THE MAJOR ISSUE FOR WHICH YOU ARE SEEKING OUR HELP? _____

_____

HOW DOES THIS ISSUE NEGATIVELY AFFECT YOUR LIFE? _____

_____

WHEN WAS YOUR LAST VISIT?_____

DENTAL INSURANCE - FIRST COVERAGE

EMPLOYEE NAME _____ ☐ SAME

EMPLOYEE DATE OF BIRTH _____ ☐ SAME

EMPLOYER _____

BUSINESS ADDRESS _____

BUSINESS PHONE _____ POSTAL _____

OCCUPATION _____

NAME OF INSURANCE COMPANY _____

POLICY/GROUP# _____

CERTIFICATE/ID/CONTRACT# _____

DENTAL INSURANCE - SECONDARY COVERAGE

EMPLOYEE NAME _____ ☐ SAME

EMPLOYEE DATE OF BIRTH _____ ☐ SAME

EMPLOYER _____

BUSINESS ADDRESS _____

BUSINESS PHONE _____ POSTAL _____

OCCUPATION _____

NAME OF INSURANCE COMPANY _____

POLICY/GROUP# _____

CERTIFICATE/ID/CONTRACT# _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____

ADDRESS _____

ARE YOU UNDER CONTINUAL PHYSICIAN'S CARE? _____

IF YES, AS OF WHICH DATE?_____ WHY? _____

WHEN WAS YOUR LAST COMPLETE PHYSICAL EXAM? _____

ARE YOU PREGNANT? ☐ YES ☐ NO ☐ UNSURE

ARE YOU TAKING ANY MEDICATION OR SUPPLEMENTS? YES / NO

IF YES, PLEASE LIST: _____

ARE YOU ALLERGIC TO ANY MEDICATION OR SUBSTANCES? YES / NO

IF YES, PLEASE LIST: _____

(IF MORE ROOM IS NEEDED USE THE LINES PROVIDED ON THE BACK OF THIS PAGE)

PLEASE TURN OVER

ARE YOU SENSITIVE OR INTOLERANT TO:

☐ ANESTHETICS ☐ ANTIBIOTICS ☐ ASPIRIN ☐ BARBITURATES ☐ PLASTIC ☐ DEMEROL

☐ CODEINE ☐ LATEX ☐ METALS ☐ PENICILLIN ☐ SULFA ☐ SEDATIVES

PLEASE CHECK ALL THAT YOU ARE SEEKING TREATMENT FOR OR HAVE EXPERIENCED/BEEN DIAGNOSED WITH IN THE LAST 12-18 MONTHS:

☐ SINUS PROBLEMS
☐ ASTHMA
☐ ALLERGIES
☐ CANCER
☐ RADIATION
☐ HEART DISEASE
☐ ARTHRITIS
☐ JAW PAIN
☐ EPILEPSY
☐ SEIZURES
☐ BLOOD DISORDERS
☐ TUBERCULOSIS
☐ AIDS
☐ CHEST PAIN
☐ BROKEN BONES

☐ CHEWING TOBACCO
☐ CHEMOTHERAPY
☐ RHEUMATIC FEVER
☐ HEPATITIS
☐ SURGERY
☐ SMOKING
☐ BLOOD CLOTTING ISSUE
☐ LEUKEMIA
☐ DIABETES
☐ CELIAC DISEASE
☐ ANEMIA
☐ HIV POSITIVE
☐ HIGH BLOOD PRESSURE
☐ ARTIFICIAL JOINTS
☐ OTHER _____

☐ HEADACHES
☐ NECK PAIN
☐ MIGRAINES
☐ PAIN WHEN CHEWING
☐ EAR PAIN
☐ DIZZINESS
☐ RINGING IN THE EARS
☐ LOWER BACK PAIN
☐ TMJ/TMD
☐ SNORING

☐ GASPING WHEN WAKING
☐ DEPRESSION
☐ FATIGUE
☐ HEARTBURN
☐ DAYTIME DROWSINESS
☐ RESTLESS SLEEP
☐ CHOKING SPELLS AT NIGHT
☐ SLEEP APNEA
☐ MEMORY LOSS
☐ BRAIN FOG

HAVE YOU EVER HAD BRACES? ☐ YES ☐ NO

DO YOU HAVE A NIGHT APPLIANCE OR SPORTS GUARD? ☐ YES ☐ NO

ANYTHING ELSE YOU WOULD LIKE TO TELL US? _____

_____

_____

PLEASE LIST ALL DRUGS & SUPPLEMENTS YOU ARE CURRENTLY TAKING:

DRUG/SUPPLEMENT	DOSAGE	INDICATION FOR USE

DO YOU WANT TO SIGN UP FOR OUR ISHINE E-NEWSLETTER? YOU WOULD BE THE FIRST TO KNOW ABOUT PATIENT APPRECIATION DAYS, PROMOS AND ALL THE LATEST NEWS! ☐ YES ☐ NO

RELEASE

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dental specialist or health care provider, only if deemed necessary for the beneficial health care of the patient.

CONSENT

- This practice DOES NOT ACCEPT ASSIGNMENT OF BENEFITS and therefore depends upon reimbursement at the time of service from the patients for the costs incurred in their care.
- Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms (and email claims) in order to assist the patient in collecting benefits from their insurance company.
- I understand that any payment plan agreement for dental care can only be extended for a period of 3 months from the date it was prepared and a fee estimate is valid for the fiscal year in which it was prepared as fees are updated on a yearly basis.

I have read the above conditions of release and consent and agree to their content AND attest to the accuracy of the information provided on this page:

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____