SHEMEN DENTAL GROUP, LLP

PATIENT INFORMATION- Date ______________________

Name ____
First MI Last Preferred Name

Address ____
Street City ST Zip

Telephone ____
Home Work Cell

Birthdate ______________________ SS# ______________________

Male ________ Female ________ Married ________ Single ________ Minor ________

Email Address ____

Place of Employment or School ____

FAMILY INFORMATION-

Please list any family members with whom you would like to share an account:

____

Who will be responsible for your account? Self ________ Other ______________________

If patient is a minor... Father ______________________ Mother ______________________

REFERRAL INFORMATION-

How did you hear about our office? ____

CHIEF COMPLAINT-

What are you being treated for today? ____

Which dentist are you seeing? Dr. C. Edward Saver, Jr. Dr. Nathaniel M. Avirett

Please list an **emergency contact**, outside of your immediate family:

____
Name Relationship Cell Number

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MEDICAL HISTORY-

Are you under a physician's care now? Yes ___ No ___ If yes, please explain: ______________________________

Have you ever been hospitalized or had a major operation? Yes ___ No ___ If yes, please explain: ______________________________

Have you ever had a serious head or neck injury? Yes ___ No ___ If yes, please explain: ______________________________

Are you taking any medications, pills, or drugs? Yes ___ No ___ If yes, please explain: ______________________________

Do you take, or have you taken, Phen-Fen or Redux? Yes ___ No ___ If yes, please explain: ______________________________

Are you on a special diet? Yes ___ No ___ If yes, please explain: ______________________________

Do you use tobacco? Yes ___ No ___ If yes, please explain: ______________________________

Do you use controlled substances? Yes ___ No ___ If yes, please explain: ______________________________

Women: Are you...

Pregnant/Trying to get pregnant? Yes ___ No ___ Taking oral contraceptives? Yes ___ No ___ Nursing? Yes ___ No ___

Are you allergic to any of the following?

___ Aspirin ___ Penicillin ___ Codeine ___ Acrylic ___ Metal ___ Latex ___ Local Anesthetics ___ Other: __________

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Y	N	Cortisone Medicine	Y	N	Hemophilia	Y	N	Renal Dialysis	Y	N
Alzheimer's Disease	Y	N	Diabetes	Y	N	Hepatitis A	Y	N	Rheumatic Fever	Y	N
Anaphylaxis	Y	N	Drug Addiction	Y	N	Hepatitis B or C	Y	N	Rheumatism	Y	N
Anemia	Y	N	Easily Winded	Y	N	Herpes	Y	N	Scarlet Fever	Y	N
Angina	Y	N	Emphysema	Y	N	High Blood Pressure	Y	N	Shingles	Y	N
Arthritis/Gout	Y	N	Epilepsy or Seizures	Y	N	Hives or Rash	Y	N	Sickle Cell Disease	Y	N
Artificial Heart Valve	Y	N	Excessive Bleeding	Y	N	Hypoglycemia	Y	N	Sinus Trouble	Y	N
Artificial Joint	Y	N	Excessive Thirst	Y	N	Irregular Heartbeat	Y	N	Spina Bifida	Y	N
Asthma	Y	N	Fainting Spells/Dizziness	Y	N	Kidney Problems	Y	N	Stomach/Intestinal Disease	Y	N
Blood Disease	Y	N	Frequent Cough	Y	N	Leukemia	Y	N	Stroke	Y	N
Blood Transfusion	Y	N	Frequent Diarrhea	Y	N	Liver Disease	Y	N	Swelling of Limbs	Y	N
Breathing Problem	Y	N	Frequent Headaches	Y	N	Low Blood Pressure	Y	N	Thyroid Disease	Y	N
Bruise Easily	Y	N	Genital Herpes	Y	N	Lung Disease	Y	N	Tonsillitis	Y	N
Cancer	Y	N	Glaucoma	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
Chemotherapy	Y	N	Hay Fever	Y	N	Pain in Jaw Joints	Y	N	Tumors or Growths	Y	N
Chest Pains	Y	N	Heart Attack/Failure	Y	N	Parathyroid Disease	Y	N	Ulcers	Y	N
Cold Sores/Fever Blisters	Y	N	Heart Murmur	Y	N	Psychiatric Care	Y	N	Venereal Disease	Y	N
Congenital Heart Disorder	Y	N	Heart Pace Maker	Y	N	Radiation Treatments	Y	N	Yellow Jaundice	Y	N
Convulsions	Y	N	Heart Trouble/Disease	Y	N	Recent Weight Loss	Y	N			

Have you ever had any serious illness not listed above? Yes ___ No ___ If yes, please explain: ______________________________

Comments: ____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

Signature of Patient, Parent, or Guardian Date

SHEMEN DENTAL GROUP, LLP

SMILE EVALUATION-

Name ____

Is there anything about your smile that you do not like?

____

Do you like the appearance of your teeth?

____

Are your teeth all in alignment?

____

Do you have any missing teeth?

____

Do you have any chipped teeth?

____

Is your bite comfortable for chewing and biting?

____

Do you have frequent headaches?

____

Do you have any old fillings or dental work that you do not like?

____

What would you like to change the most in the appearance of your teeth?

____

Are you familiar with the new techniques in dentistry?

____

If money were no object, what would you change about your smile?

____

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INSURANCE INFORMATION-

Patient Name ______________________________

Patient's Relationship to Insured: Self ________ Spouse ________ Child ________ Other ________

Cardholder's Name ______________________________

Cardholder's Address ______________________________

Cardholder's Employer ______________________________

Cardholder's Date of Birth ______________ Cardholder's SS# ______________

Insurance Company ______________________________

Insurance Company's Address ______________________________

Group # ______________ ID # ______________

I understand that insurance may not pay 100% of my incurred charges. I agree that any balance not covered by insurance is my financial responsibility.

____
Printed Name

____
Signature of Patient or Guardian

____
Date

FINANCIAL ARRANGEMENTS-

It is our goal to provide you with as many options as possible for you to receive optimum dental care.

Option 1 CareCredit: Our office has contracted with CareCredit so that we can offer you another payment option. The qualification process is simple and can usually be completed within 20 minutes. You have numerous options within this program that range from 12 months with no interest to extended payment plans with interest. There is no discount for payment in full with CareCredit.

Option 2 Preauthorized Payment Option: This option allows you to extend payment up to three months with no interest. A 30% down payment is required prior to the beginning of treatment. The remaining monthly payments are handled through pre-authorization of payment through your checking, savings, or credit card account. You simply choose a day of the month that is convenient for you, and our office will draft your payment on the day specified.

Option 3 One-half of the fees for treatment will be due when treatment is started and the remaining one-half will be due upon completion of your treatment. If it will suit your financial needs better, we can divide your treatment into phases. We can then use this option with each phase. When one phase is completed financially, we will progress to the next phase.

Option 4 Our practice offers a savings program for patients willing to pay the entire fee for their treatment on or before the day the treatment begins. For treatment that exceeds $400, we offer a professional courtesy of 5% for cash or check payments, and 3% for Visa, MasterCard, or Discover payments. The treatment must be paid in full on or before the day the services are performed to be eligible to receive the 'up-front' discount.

Option 5 Senior Citizens (60 years plus) will receive a 5% discount for payment with cash or check, and a 3% discount for Visa, MasterCard, or Discover for treatment that is paid in full on or before the time of service.

A Word about Insurance –

We are happy to cooperate with our patients who are covered by dental insurance. We will file your insurance for you. Our only requirement is that your portion is due at the time treatment is initiated. It is uncommon to see an insurance company cover all treatment. It is our goal to help you obtain the maximum reimbursement to which you are entitled.

SHEMEN DENTAL GROUP, LLP

CONSENT FOR TREATMENT-

I hereby voluntarily consent to treatment at the office of Shemen Dental Group, LLP. This includes routine diagnostic procedures, examinations, and procedures deemed necessary by the treating dentist.

Shemen Dental Group, LLP has my permission to post photographs of my dental work within their dental practice and on their website, social media accounts, videos or slideshow presentations, print ads, and all other marketing or advertising efforts that promote their dental practice.

I understand that this consent form will be valid and remain in effect as long as I seek treatment from Shemen Dental Group, LLP.

I hereby authorize my insurance carrier to pay directly to Shemen Dental Group, LLP all benefits due me.

____

Printed Name

____

Signature of Patient or Guardian

____

Date

If patient is a minor or is unable to consent, please complete the following:

*Patient is a minor; patient is __________ years of age.

Name of Father ______________________________

Name of Mother ______________________________

*Patient is unable to consent because ____