Today's Date: _______________

Name ___________________________ Birthdate _________________________

Social Security # _________________ Drivers License # __________________________ State___

Address ____ City ____________ State ____ Zip _____

Phone (H)_______________ (W) ________________ (C) __________________

Email ____

Please circle Minor Single Married Divorced Widowed Separated

Preferred Pharmacy ____

Employer ______________________________ Employer Phone # ____________________________

Spouse/Parent's Name __________________________ Employer ____________________________

If a student, name of school/college ____

Emergency Contact _________________________________ Phone _____________________________

Whom may we thank for referring you? ____

Insurance Information

Name of Subscriber ___________________________ Relationship to patient _____________________

Birthdate ________________________ Social Security # ________________________

Name of Employer _____________________________________

Insurance Company Name __________________ Member ID_______________ Group # __________

Insurance Company Phone Number for Benefits/Providers _____________________________________

Medical History

Patient Name __________________________ Preferred name ______________________ Age ____
Name of Physician ____
Most recent physical exam? ____________________ Reason _________________________________
What is your estimate of your general health? ____ Excellent _____ Good _____Fair ______Poor

Have you ever had an allergic reaction to:

___ Ibuprofen
___ Penicillin
___ Erythromycin
___ Tetracycline
___ Sulfa
___ Clindamycin
____ Codeine
____ Tylenol
____ Tramadol
____ Latex
____ Other ______________________

Do you have, or have you ever had and when

Yes Date No

___ ____ ___ Hospitalization for illness or injury in the last 2 years
___ ____ ___ Heart problems, or surgery within the last six months
___ ____ ___ Can you walk up a flight of stairs without having to stop and rest or getting short of breath?
___ ____ ___ History of ineffective endocarditis
___ ____ ___ Artificial heart valve or repaired heart defect (PFO)
___ ____ ___ Pacemaker or implantable defibrillator
___ ____ ___ Artificial prosthesis (heart valve, hip or knee replacement, joints)
___ ____ ___ High blood pressure
___ ____ ___ Low blood pressure
___ ____ ___ Stroke
___ ____ ___ COPD
___ ____ ___ Tuberculosis
___ ____ ___ Asthma
___ ____ ___ High cholesterol or taking statin drugs
___ ____ ___ Diabetes (Type 1 or Type 2)
___ ____ ___ Are you taking anything for Osteoporosis (soft bones) (i.e. bisphosphonates)
___ ____ ___ Is it uncomfortable for you to sit in a dental chair in the laid-back position?
___ ____ ___ Epilepsy or Convulsions
___ ____ ___ Hepatitis (type ____)
___ ____ ___ Blood Thinners
___ ____ ___ Kidney Disease
___ ____ ___ Liver Disease
___ ____ ___ Dizziness/History of fainting
___ ____ ___ HIV/AIDS
___ ____ ___ Have you undergone chemotherapy or radiation?
___ ____ ___ Smoker, previous smoker or use smokeless tobacco
___ ____ ___ FEMALE – Pregnant
___ ____ ___ Do you have any health issues that we need to discuss or that could possibly affect your dental treatment? If yes, please explain
____

Please list all medications, supplements, and/or vitamins taken within the last two years (or provide a list to office)

____
____

____________________________ ___________________
Patient Signature Date

____
Doctor Signature

Dental History

Full name _____________________________ Date of birth: ___________________________
How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous dentist ____________________________ How long were you a patient? _____________
Date of most recent: Exam _______________ X-rays _______________ Treatment ________________
What is your immediate concern? ____

Please check yes or no to the following:
On a scale of 1 (least) to 10 (most), how fearful are you of dental treatment? ________________________

Yes No
___ ___ Have you had an unfavorable dental experience?
___ ___ Have you ever had complications from past dental treatment?
___ ___ Have you ever had trouble getting numb or had any reactions to local anesthetic?
___ ___ Did you ever have braces, orthodontic treatment or had your bite adjusted/
___ ___ Have you had any teeth removed?

Smile Characteristics
___ ___ Is there anything about the appearance of your teeth you would like to change?
___ ___ Have you ever whitened (bleached) your teeth?
___ ___ Do you feel uncomfortable or self-conscious about the appearance of your teeth?
___ ___ Have you been disappointed with the appearance of your pervious dental work?

Bite and Jaw
___ ___ Do you have problems with your jaw joint? (pain, sounds, limited opening, locking)
___ ___ Have your teeth changed in the last 5 years, become shorter, thinner or worn?
___ ___ Are your teeth crowding or developing space?
___ ___ Do you clench your teeth in the daytime or make them sore?
___ ___ Do you have any problems with sleep or wake up with an awareness of your teeth?
___ ___ Do you wear, or have you ever worn a bite appliance?

Tooth Structure
___ ___ Have you had any cavities within the last 3 years?
___ ___ Do you seem to have too little saliva, or do you have difficulty swallowing food?
___ ___ Do you feel or notice any holes (i.e. pitting, craters) on the biting surfaces of your teeth?
___ ___ Are any teeth sensitive to hot, cold, biting, sweets?
___ ___ Do you avoid brushing any part of your mouth?
___ ___ Do you have grooves or notches on your teeth near the gum line?
___ ___ Have you ever broken teeth, chipped teeth or had a toothache and cracked filling?
___ ___ Do you frequently get food caught between any teeth?

Gum and Bone
___ ___ Do your gums bleed or are they painful when brushing or flossing?
___ ___ Have you ever been treated for gum disease or been told you have lost bone around your teeth?
___ ___ Have you ever noticed an unpleasant taste or odor in your mouth?
___ ___ Has anyone in your family had a history of periodontal disease?
___ ___ Have you ever experienced gum recession?
___ ___ Have you ever had any teeth come loose on their own (without an injury)?
___ ___ Have you experienced a burning sensation in your mouth?

Shiloh Family Dental

Dental Benefits and Explanation

The patient is responsible for**:**

- Understanding their insurance coverage
- Informing the office of any changes in your insurance coverage
- Shiloh Family Dental will submit dental claims to your carrier. We also accept benefit assignment, meaning we will **estimate** the expected benefit payment and allow you to pay your **estimated** portion at the time services are provided.
- Shiloh Family Dental requires a 50% deposit to schedule treatment. This deposit allows us to know patients will be coming to appointments as scheduled so we can confidently reserve time for you. The remaining 50% is due the day services are rendered.
- While Shiloh Family Dental strives to provide an accurate estimate of anticipated insurance benefits, patients are **fully responsible for any balance due after insurance has paid their portion. We take no responsibility for any denials by patient dental plans.**

Any service we provide cannot be billed to Medicaid or DHMO dental insurance plans.

Payment options:

Payment for patient's portion is due in full on the date of service. Payment may be made by cash, check, Visa, Mastercard, Discover, American Express, CareCredit or LendingClub patient financing.

Cancellation and Rescheduling Policy:

Shiloh Family Dental strives to provide quality dental care in a timely manner. When we schedule an appointment for you, we reserve time for you. Because of this, we do require 24 hours notice to cancel or reschedule an appointment. Last minute cancellations and rescheduling results in open time that we cannot serve another patient. If appointments are canceled or rescheduled in less than 24 hours a **$75 fee will be accessed**.

Please read the following authorization and sign for our files.

I hereby authorize the release of any dental information necessary to process insurance claims or be referred to dental or medical offices. I authorize payment of benefits to the dentist described herein for services rendered. I have also read the above sections and agree to the terms therein.

____________________ _______________________________ __________________

Name (printed) Signature Date

Shiloh Family Dental Notice of Privacy Practices

Notice of Privacy Policies
Review our Notice of Privacy Practices for a more complete description of how your Protected health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Heath Information
Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I give permission for the use and disclosure of my health information as set forth above. In addition, my personal health information may be disclosed to the individuals listed below:

List individuals who we may discuss your dental care with.

_________________________ _____________________________
Date Time

Patient's Printed Name ____

Witness Signature ____

__________________________ ______________________________
Date Time

Shiloh Family Dental Social Media Use and Consent

Consent to Use and Disclose Treatment Information and Photographs for Social Media Purposes

We value our patients' right to privacy and confidentiality, and we take our responsibilities under HIPAA and the Texas Medical Records Privacy Act very seriously. The practice exercises great care in the use of patient images and patient identities to promote the practice via social media. Specifically, we pledge not to disclose or discuss:

- Your past, present or future physical or dental health or condition;
- Discriminatory or potentially negative information of a personal or professional nature; and
- Past, present or future payment for your health care.

By signing below, you grant our office permission to use an approved photograph of yourself along with a brief description of featured work or reason for posting for promotional purposes on social media.

You understand that this authorization may be revoked at anytime merely by notifying our office that you wish us to discontinue using your photograph(s) and brief description(s) for promotional purposes.

Finally, your willingness to participate in social media promotion will have no effect on the treatment you receive from our office and staff. If you decline to allow us to use your photographs(s) and description(s), your treatment or experience as a patient of our practice will not be affected.

Patient name ____

Patient or Guardian Signature ____

Date Signed ____