Last Name: ____________________________ First Name: ______________________________ M.I.: __ Title: ________

Preferred Name: __________________________________________________________________ ❑ Male ❑Female

Address: ____________________________________ Apt: ____ City: ___________________State: _____Zip Code: _______

SS#: _____________________________________________ Date of Birth: ________________________________________

Home Phone: ______________________________________ Work Phone: ________________________________________

Cell Phone: ________________________________________ E-mail Address: ______________________________________

Employer: _________________________________________Occupation: ________________________________________

Marital Status: ❑Single ❑ Married ❑Child ❑Other

How did you hear about us? ______________________________________________________________________________

## ■Primary Insurance■

Subscriber Name: ______________________________ Relationship to Patient: ___________ Subscriber DOB: _________

Subscriber SS# / ID#: _____________________________ Subscriber Employer: ____________________________________

Insurance Company Name: _________________________________________________________________________________

Insurance Company Address: _______________________________________________________________________________

Insurance Company Phone: _______________________ Group Number: ___________________________________________

## ■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Shine Dental Arts all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:______________________________________________________________________________

Relationship: _____________________________________________ Date: __________________________________________

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: ______________________________________________________________________________

Are you currently under the care of a physician? ❑ Yes ❑ No If Yes, please explain: ____________________________

Physician's Name: ___________________________________________Physician's Phone: ___________________________

Date of last visit with your Physician: ______________________________

Do you use tobacco in any form? ❑ Yes ❑ No

Have you had any joint replacements, heart surgery or implants? ❑ Yes ❑ No

Has a doctor told you that you require antibiotic premedication before dental treatment? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No If yes, please list each medication/dosage: _________________________

_____________________________________________________________________________________________________

Have you ever had any surgical procedures? ❑ Yes ❑ No Please list each one ___________________________________

_____________________________________________________________________________________________________

| Yes | No | **Conditions** | Yes | No | **Conditions** | Yes | No | **Conditions** |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Abnormal Bleeding | ❑ | ❑ | Frequent Headaches | ❑ | ❑ | Sexually Transmitted Disease |
| ❑ | ❑ | Alcohol Abuse | ❑ | ❑ | Glaucoma | ❑ | ❑ | Shingles |
| ❑ | ❑ | Allergies | ❑ | ❑ | HIV+ Aids | ❑ | ❑ | Tobacco/Vaping Use |
| ❑ | ❑ | Anemia | ❑ | ❑ | Heart Attack | ❑ | ❑ | Sinus Problems |
| ❑ | ❑ | Asthma | ❑ | ❑ | Heart Murmur | ❑ | ❑ | Stroke |
| ❑ | ❑ | Arthritis | ❑ | ❑ | Heart Surgery | ❑ | ❑ | Thyroid Problems |
| ❑ | ❑ | Artificial Heart Valve | ❑ | ❑ | Hemophilia | ❑ | ❑ | Tuberculosis |
| ❑ | ❑ | Birth Control | ❑ | ❑ | Hepatitis A | ❑ | ❑ | Ulcers |
| ❑ | ❑ | Blood Transfusion | ❑ | ❑ | Hepatitis B | | | |
| ❑ | ❑ | Cancer | ❑ | ❑ | Hepatitis C | Yes | No | **Allergies** |
| ❑ | ❑ | Chemotherapy | ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Aspirin |
| ❑ | ❑ | Colitis | ❑ | ❑ | Joint Replacements | ❑ | ❑ | Codeine |
| ❑ | ❑ | Congenital Heart Defects | ❑ | ❑ | Kidney Problems | ❑ | ❑ | Dental Anesthetics |
| ❑ | ❑ | Diabetes | ❑ | ❑ | Liver Disease | ❑ | ❑ | Erythromycin |
| ❑ | ❑ | Difficulty Breathing | ❑ | ❑ | Low Blood Pressure | ❑ | ❑ | Jewelry |
| ❑ | ❑ | Drug Abuse | ❑ | ❑ | Mitral Valve Prolapse | ❑ | ❑ | Latex |
| ❑ | ❑ | Emphysema | ❑ | ❑ | Pace Maker | ❑ | ❑ | Metals |
| ❑ | ❑ | Epilepsy | ❑ | ❑ | Psychiatric Problems | ❑ | ❑ | Penicillin/Amoxicillin |
| ❑ | ❑ | Facial Surgery | ❑ | ❑ | Radiation Therapy | ❑ | ❑ | Tetracycline |
| ❑ | ❑ | Fainting Spells | ❑ | ❑ | Rheumatic Fever | | Other: | ___________________ |
| ❑ | ❑ | Fever Blisters | ❑ | ❑ | Seizures | | | |

If Female, is there any chance that you are pregnant? ❑ Yes ❑ No; If yes, how many weeks? _______

In an emergency, who should be notified? Name: ____________________________Relationship: _________________
Phone: __________________________________

Name and phone number of preferred pharmacy _____________________________________________________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _______________________________________________________Date: __________________________________

How may we help you today? ______________________________________________________________

If you could change one thing about your smile, what would it be? ________________________________

On a scale of 1-10, what is your desire to make that change? _______

How would you rate your current dental health? ❑ Good ❑ Fair ❑ Poor

Are you currently experiencing any pain in your mouth? ❑ Yes ❑ No If Yes, then where? ________________

Are you interested in seeing what your teeth would look like after an Invisalign treatment (Clear Braces)? ❑ Yes ❑ No

Have you ever had periodontal (gum) treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Do your gums bleed when you brush or floss? ❑ Yes ❑ No

Are your teeth sensitive to hot, cold or biting? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Do you snore or has anyone told you that you snore? ❑ Yes ❑ No

Do you clench or grind your teeth? ❑ Yes ❑ No

When was your last dental cleaning? _____________When was your last dental visit? ______________________

Why did you leave your previous dentist?_____________________________________________________

Are there any special accommodations that we need to know about? ___________________________________

Here at Shine Dental Arts, we provide our patients with many various services that will maintain and/or enhance your smile. Please circle any services below you would like our friendly staff to discuss with you during your visit.

| | | |
|---|---|---|
| Tooth Whitening | Implants | Sleep Apnea Device |
| Invisalign Clear Aligners | Smile Makeover | Composite fillings/ Bonding |
| Sealants | Crowns | Veneers |
| Partials/Dentures | Nightguard/Sport Guards | |

# Shine Dental Arts' Financial Policy

We appreciate that you have chosen our office for your oral health care needs. We understand that all of our patients have their own unique financial situation. In an effort to accommodate everyone, we provide our patients with different payment options that will aid in helping you receive that dental care. Treating your dental needs is an excellent investment to ensure a healthy quality of life. We are here to answer any questions that you may have in the process.

We want to prevent any potential financial misunderstandings, so we ask our patients to accept and observe to the financial arrangements regarding their dental treatment listed below:

This office will submit the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. Any remaining portion not paid or covered by the insurance companies is to be paid by the patient.

Full payment is due at the time of service unless arrangements have been made prior to the start of treatment. We accept cash, checks, debit cards, and all major credit cards.

**Financing Option:** We use Care Credit for all patients seeking financing for their dental treatment.

Insurance balances are ultimately the patient's obligation. As a courtesy, we will file your primary insurance at no cost. Insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment. In the event that your insurance carrier only covers a portion of the treatment, the remaining balance will be your responsibility.

There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF).

We reserve the right if balances are unpaid for 60 days or more to do one or more of the following charges:

- Interest Charges of 1.5% per month or 18% APR
- Collection fees (up to 42% of the full balance)
- Legal fees for collection services

We reserve and prepare a room specific to your dental needs whenever an appointment is made, so we strongly encourage patients to keep their appointments. In the event that you need to reschedule your appointment time, we would appreciate at least 48-hour notice.

Signature: ______________________________________________________ Date: _________________________________

## Patient Consent to Receive Mail and/or Telephone Messages

Last Name: ___________________________ First Name: ______________________________ M.I.: __ Title: _________

Do we have your permission to:

A. Send a recall appointment reminder to your home? ❑ Yes ❑ No

B. Leave appointment, billing or dental information on your answering machine, voicemail, text, or email? ❑ Yes ❑ No

---

I give permission to share appointment, billing or dental information with the person named below:

Last Name: ___________________________ First Name: ______________________________ M.I.: __ Title: ________

_________________________________________________________ _________

Signature of Patient / Parent or Legal Guardian Date

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## Acknowledgement of Receipt of Notice of Privacy Practices- HIPAA

I have received a copy of the Notice of Privacy Practices

______________________________________________________ __________

Signature of Patient / Parent or Legal Guardian Date

If there are any additional recommendations, requests, or information that you feel we should know, please feel free to express yourself in the following lines:

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

SHINE
DENTAL ARTS

# Airway Obstruction Screening

At Shine Dental Arts, we screen our patients for any signs in the oral cavity of airway issues and also improper breathing that could contribute to systemic disease in the body like high blood pressure and diabetes. This quick questionnaire aids us in that process of determining if there are any airway obstructions occurring on a consistent basis.

## *Epworth*

Please rate the following scenarios on how likely you are to fall asleep:

**0** = No Chance, **1** = Slight Chance, **2** = Moderate Chance, **3** = High Chance

| Scenario | | | | |
|---|---|---|---|---|
| Sitting and Reading | **0** | **1** | **2** | **3** |
| Watching TV | **0** | **1** | **2** | **3** |
| Sitting inactive in a public place | **0** | **1** | **2** | **3** |
| Lying down to rest in the afternoon when circumstances permit | **0** | **1** | **2** | **3** |
| Sitting in a car as a passenger for a continuous hour | **0** | **1** | **2** | **3** |
| Sitting and talking to someone | **0** | **1** | **2** | **3** |
| Sitting quietly after a lunch without alcohol | **0** | **1** | **2** | **3** |
| Sitting in a car stopped in traffic for a few minutes | **0** | **1** | **2** | **3** |
| Total | | | | |

**Score:** Add up your score for each scenario: **0-10** Normal Range l **10-12** Borderline l **12-24** Sleepy