■Personal Information■

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? _____

■ 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: _____

SHINE
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■Medical History■

Physician's Name: _____Physician's Phone: _____

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 _____

_____

If Female, is there any chance that you are pregnant? ❑ Yes ❑ No

Name and phone number of pharmacy: _____

Yes	No	**Conditions**
❑	❑	Abnormal Bleeding
❑	❑	Acid Reflux/ GI Disorders
❑	❑	Anemia
❑	❑	Asthma
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Atrial Fibrillation
❑	❑	Cancer
❑	❑	Chemotherapy
❑	❑	Congenital Heart Defects
❑	❑	Dementia
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Eating Disorders
❑	❑	Emphysema
❑	❑	Epilepsy/Seizures
❑	❑	Facial Surgery
❑	❑	Fainting Spells
❑	❑	Frequent Headaches

Yes	No	**Conditions**
❑	❑	HIV+/AIDS
❑	❑	Heart Attack
❑	❑	Heart Murmur
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	Hepatitis C
❑	❑	High Blood Pressure
❑	❑	Kidney Disease
❑	❑	Liver Disease
❑	❑	Pacemaker
❑	❑	Parkinson's Disease
❑	❑	Psychiatric Disorder
❑	❑	Radiation Therapy
❑	❑	Seasonal Allergies
❑	❑	Sinus Disorder
❑	❑	Sleep Apnea
❑	❑	Stroke
❑	❑	Thyroid Disorders
❑	❑	Tobacco/Vape
❑	❑	Tuberculosis

Yes	No	**Allergies**
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Latex
❑	❑	Metals
❑	❑	Penicillin/Amoxicillin
❑	❑	Sulfa
Other:		_____

■ Emergency Contact■

Name: _____Relationship: _____ Phone: _____

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: _____

■Dental History■

Are there any specific concerns or issues you would like us to address during your appointment?

_____

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

Would you like a complimentary digital teeth scan to visualize the potential results of Invisalign (clear braces) treatment? ❑ Yes ❑ No

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

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

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

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

Is there any additional information you would like to share regarding your previous dental office experience?

_____

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

■ 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 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.

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

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**

Score: Add up your score: **0-10** Normal Range l **10-12** Borderline l **12-24** Sleep Total _____

■Financial Policy■

We appreciate that you have chosen Shine Dental Arts for your oral health care needs. We understand that every patient has unique financial situations, and we are here to help. To ensure clarity and comfort, here are the key points to our financial policy:

- **Payment Options:** Payment is due at the time of service. We accept cash, checks, debit cards, and all major credit cards. **Initial _____**

- **Insurance:** We will submit your insurance forms and help collect payments. Any amount not covered by insurance is the patient's responsibility. **Initial _____**

- **Financing:** We offer Care Credit for patients seeking financing for their dental treatment. Please ask for more information if you are interested. **Initial _____**

- **Balances:** We utilize Abella, a third-party service, to notify you of any outstanding balances. You will receive notifications via text or email regarding your balance. Additionally, we may reach out through text, phone call, or mail to remind you of unpaid balances. We kindly request that you settle any outstanding balances promptly. If you encounter any extenuating circumstances, please inform us so that we can collaborate on creating a suitable plan moving forward. **Initial _____**

- **Appointment Changes:** We reserve time and prepare a room specifically for your dental needs. If you need to reschedule, please provide at least 48-hour notice. We do not charge for missed appointment, but we would greatly appreciate your commitment to the scheduled appointment times. **Initial _____**

Thank you for understanding and cooperating with our financial policies. We're here to answer any questions you might have and to make your experience as smooth and pleasant as possible.

Signature: _____ **Date:** _____

■ Patient Consent to Receive Mail, Text, and Telephone Messages ■

We utilize texting as a convenient and efficient method to communicate important information and reminders to our patients.

Do we have your permission to:

- Send a recall appointment reminder to your phone/home? ❑ Yes ❑ No
- Leave appointment, billing or dental information on your answering machine, voicemail, text, or email? ❑ Yes ❑ No

■ Consent to Share Information ■

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

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

We have our Notice of Privacy Practices for any patient requesting a copy at the front desk.

_____ _____

Signature of Patient / Parent or Legal Guardian Date

■ Additional Requests■

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:

_____

_____

_____