

Shelton Dental Excellence

New patient forms

Personal Information

Name: _____ DOB: _____

Address: _____ City: _____ St. _____ Zip _____

Home Phone# _____ Cell Phone # _____

Email: _____ SSN: _____

Sex: Male Female Married Single Other: _____

Emergency Contact: _____ Phone# _____

Person Responsible for account: _____

IF PATIENT IS A MINOR:

Parent/Guardian Name: _____ Relation: _____

DOB: _____ Address:(if different than above) _____

Phone #: _____

Insurance information:

Primary

Insurance company: _____ ID# _____

Subscriber: _____ SUB DOB _____ Relation: _____

Secondary

Insurance company: _____ ID# _____

Subscriber: _____ SUB DOB _____ Relation: _____

All information provided was true, and correct to the best of responsible persons knowledge

Signature: _____ Date _____

If dental insurance applies: although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company as we have no control over the insurance company's decision to pay for a provided service. All amounts remaining after insurance payment is patient responsibility. Initials: _____

HIPPA acknowledge of Receipt of Notice of privacy practices

You may share my information with: _____

Print name: _____ Signature: _____ Date: _____

****you may refuse to sign this acknowledgment Patient refused to Sign HIPPA**

Payment and Cancellation Policy

Payment is expected at time of service. For your convenience we take cash, checks, Care Credit, Credit and Debit cards. The office is happy to submit claims to your insurance company. I understand that Shelton Dental Excellence will make every effort to collect payment from my insurance company. I hereby authorize Shelton Dental Excellence to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services rendered covered by insurance for services rendered to me or my dependents **Initial:** _____

Please understand that the appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointments are in high demand, we value advanced notice from our patients who are unable to keep their scheduled appointment.

In an effort to decrease unnecessary costs related to staffing and supplies and in order to contain our costs and continue to provide you with affordable fine dentistry for your entire family, we maintain a No-Show/Cancellation Policy for all patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or unable to be kept, must be canceled at least 24 hrs in advance of the scheduled time. Cancellations must be made during business hours on work days, at least one full business day prior to the scheduled appointment, Cancellations must be done over the phone or speaking directly to one of dental professionals. Patients will not be charged if the cancellation is done 24 hours before their appointment. **Initial:** _____

Since we certainly understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or canceled appointment. In the event a second appointment is missed or canceled with less than 24 hour notice, or no notice, a \$50 charge will be billed to the account. This fee will need to be paid before scheduling any future appointments. If a third no show or same day cancellation occurs, we reserve the right to terminate the doctor-patient relationship as well as an additional \$50 charge. **Initial:** _____

This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy.

Signature: _____

Patient Name printed: _____ Date: _____

Relationship to patient: _____

Informed Consent Form for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risk and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on birth control medications, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physicians before relying on oral birth control medication if your dentist prescribes antibiotics.

In an effort to control the increasing cost of dental care, any disputes against this office shall be resolved by "binding arbitration." By signing this agreement, the patient agrees with the office Shelton Dental Excellence, that any dispute relating to dental or medical care services for any condition, (including any services rendered prior to the date of this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care for the patient, including to the full extent permitted by applicable law third parties who are not signatories to this agreement (including associates)) shall be resolved by binding arbitration by the National Arbitration Forum, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and occur occasionally. Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

- Pain, swelling, and discomfort after treatment.
- Infection in need of medication, follow-up procedure or other treatment,
- Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
- Damage to adjacent teeth, restoration or gums.
- Possible deterioration of your condition which may result in tooth loss.
- The need for replacement of restorations, implants or other appliances in the future.
- An altered bite in need of adjustment,
- Possible injury to the jaw and related structures. Requiring follow-up care and treatment, or consultations by a dental specialist.
- A root tip, fragment or piece of instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
- Jaw fracture.
- If upper teeth are treated, there is a chance of sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
- Allergic reaction to anesthetic or medication.
- Need for follow up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood and accepted each paragraph stated above. Please discuss the potential risks, and complications of recommended treatment with your dentists. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Signature:

Date: _____

Medical History

Are you currently under a physician's care? Yes No If yes, _____

Have you ever been hospitalized or had a major operation? Yes No if yes, _____

Have you ever had a serious head or neck injury? Yes No If yes, _____

Do you take, or have you taken Phen-fen or Redux? Yes No If yes, _____

Do you use Tobacco? Yes No If yes, _____

Are you on a special diet? Yes No If yes, _____

Have you ever taken Fosamax, Boniva, Actonel, Yes No If yes, _____
or any other medication containing bisphosphonates?

Are you taking Aspirin or any other blood thinners? Yes No If
yes, _____

Do you use or have you used controlled substances? Yes No If yes, _____

Are you taking any medications, pills, or drugs? Yes No If yes, _____

List all medications, Drugs, or Herbal remedies:

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

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anaphylaxis disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/gout <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing problems <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise easily
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine
Diabetes I/II <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema/copd
Epilepsy/seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting spells/dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headache
Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble/disease
Bleeding disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B/C <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High/low blood pressure
Hives/Rash <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney problems
Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis
Pain in jaw joints <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments
Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble
Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs
Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/Growths <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immunocompromised <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acid Reflux
Dry Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinsons <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	HPV

Have you ever had an illness not listed? Yes No If yes, _____

Have you ever had any of the following? Please name type and year:

Cancer: Yes No If yes, _____

Stroke/Heart Attack Yes No If yes, _____

Artificial Joint Yes No If yes, _____

Organ Transplant Yes No If yes, _____

Women are you;

Pregnant or trying to get pregnant YesNo

Nursing? YesNo

Taking oral contraceptives? YesNo

Are you allergic to any of the following:

Aspirin YesNo

Penicillin YesNo

Codeine YesNo

Acrylic

YesNo

Metal YesNo

Latex

YesNo

Sulfa Drugs YesNo

Local Anesthetics

YesNo

Do you have any allergies NOT listed? YesNo **If Yes,** _____

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 patients) health. It is my responsibility to inform the office of any changes in my medical status.

Print Name: _____ **Date:** _____

Signature: _____