Shambaugh
DENTAL GROUP

Patient Information:

First Name:_____ Last Name: _____ D.O.B:_____

Address_____ SSN:_____

City, State, Zip Code: _____

Home Phone_____ Work Phone:_____

Cell Phone:_____ Email:_____

Ok to receive email or text correspondence? (Appt reminders, etc): YES NO

Sex: M or F Marital Status: Single Married Divorced Separated Widowed Partnered

Emergency Contact:_____ Phone:_____

Last dental visit _____ Dentist Name _____

How did you hear about our office? _____

Responsible Party: First Name: _____ Last Name: _____

Address: _____ Phone: _____

City, State, Zip Code: _____

Primary Insurance Information:

Name of Insured:_____ Relationship to Patient_____ DOB of Insured:_____

Insured's Employer: _____ Employer Phone: _____

Insurance Company: _____ Insurance Phone: _____

Please carefully read below:

I, THE UNDERSIGNED HEREBY AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THROUGH DIAGNOSIS OF THE PATIENTS DETERMINED NEEDS. I ALSO AUTHORIZE SHAMBAUGH DENTAL GROUP TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMOBIES A CERTAIN RISK AND UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND ME, AND BETWEEN THE INSURANCE CARRIERS AND SHAMBUAGH DENTAL GROUP, AND THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO SHAMBAUGH DENTAL GROUP AND PAYMENTS RECEIVED BY THE DOCTOR FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT AND WILL BE REFUNDED TO ME, UPON REQUEST, IF I HAVE PAID THE DENTAL FEES INCURRED. I FURTHER UNDERSTAND THAT AN ADDITIONAL CHARGE WILL BE ADDED TO ANY OVERDUE BALANCE. I HAVE READ AND UNDERSTAND THAT NOTICE OF PRIVACY PRACTICE AS REQUESTED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA").

If you are unable to keep your appointment, we require at least 24 hours' notice so that your reserved time may be made available for other patients. Patients who miss an appointment or cancel with less than 24 hours' notice will be assessed a $45.00 fee.

_____ _____

Patient/Guardian Signature Date

Although dental personnel primarily treat area in and around your mouth, your mouth is part of your entire body. Health problems that you have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under the care of a physician's care now?	O Yes O No	If Yes _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If Yes _____
Have you ever had a serious head or neck injury?	O Yes O No	If Yes _____
Are you taking any medications, pills or drugs?	O Yes O No	If Yes _____
Do you take, or have taken, Phen-Fen or Redux?	O Yes O No	If Yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes O No	If Yes _____
Are you on a special diet?	O Yes O No	If Yes _____
Do you use tobacco?	O Yes O No	If Yes _____
Do you use controlled substances?	O Yes O No	If Yes _____

Women: Are you… O Pregnant/Trying to get pregnant? O Nursing O Taking oral contraceptives

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex

O Sulfa Drugs O Local Anesthetics O Other _____

Have you had any of the following?

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No
Alzheimer's	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	High Cholesterol	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hives or Rash	O Yes O No
Artificial Joints	O Yes O No	Excessive Thirst	O Yes O No	Hypoglycemia	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Kidney Problems	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Leukemia	O Yes O No
Breathing Problems	O Yes O No	Frequent Headaches	O Yes O No	Liver Disease	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Low Blood Pressure	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Lung Disease	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Mitral Valve Prolapse	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Osteoporosis	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur	O Yes O No	Pain In Jaw Joints	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pacemaker	O Yes O No	Parathyroid Disease	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Psychiatric Care	O Yes O No

Radiations Treatments	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Recent Weight Loss	O Yes O No	Stroke	O Yes O No
Renal Dialysis	O Yes O No	Swelling of Limbs	O Yes O No
Rheumatic Fever	O Yes O No	Thyroid Disease	O Yes O No
Rheumatism	O Yes O No	Tonsillitis	O Yes O No
Scarlet Fever	O Yes O No	Tuberculosis	O Yes O No
Shingles	O Yes O No	Tumors or Growths	O Yes O No
Sickle Cell Disease	O Yes O No	Ulcers	O Yes O No
Sinus Troubles	O Yes O No	Venereal Disease	O Yes O No
Spina Bifida	O Yes O No	Yellow Jaundice	O Yes O No

Have you ever had any serious illness not listed above? O Yes O No If Yes _____

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

_____

Printed Name of Patient

Shambaugh
DENTAL GROUP

Insurance Release and Financial Policy

For those patient who have insurance coverage:

1. In consideration of my doctor rendering dental services to me or a member of my family for whom I am financially responsible, I hereby assign to my doctor all insurance which I have a right to in regard to his/her bill.
2. This assignment does not constitute payment for indebtedness and does not relieve the undersigned from liability for unpaid indebtedness.
3. In the event the insurance carrier pays benefits to me (instead of to my doctor as I hereby request) for services performed, I agree that I will immediately deliver all such benefits to my doctor up to the amount of my indebtedness to him.

For those patients who do not have insurance coverage:

If I do not have insurance coverage, I understand that I am financially responsible for all bills incurred during my treatment.

Authorization for release of information:

Dr. Shambaugh, Dr. Hertig and Dr. Acosta are hereby authorized to furnish such professional information as may be necessary for the completion of my insurance claim from the medical records compiled during my treatment. Dr. Shambaugh, Dr. Hertig and Dr. Acosta are hereby released from all legal liability that may arise from the release of the information requested.

I (we) further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made at discharge, or within (30) thirty days of discharge to pay for in-office processing fees. I (we) further agree to pay collection costs and reasonable attorney fees if this account is placed in the hands of a collection agency or attorney.

I have read the above and foregoing and fully understand the terms thereof.

_____ _____

Signature of Patient/Responsible Party Date

_____

Printed name of Patient/Responsible Party

Shambaugh
DENTAL GROUP

SHAMBAUGH DENTAL GROUP BILLNG PROCESS

Thank you for choosing Shambaugh Dental Group. In efforts to better serve you, we would like to take the time to explain the billing process at our office.

Once you provide the office with your dental Insurance, we call your insurance company and verify your benefits. The information we receive from your insurance company is only an estimation of coverage and not a guarantee. After you have been seen in our office, we will file your claim to the insurance company directly. If the insurance company does not cover the estimated amount in full, you will receive a statement in the mail and be responsible for the remaining account balance.
Thank you again for choosing Shambaugh Dental Group for your dental needs. We look forward to a long lasting relationship with you.

I have read and understand the billing process at Shambaugh Dental Group.

_____	_____	_____
Patient's Name (Printed)	Patient's Signature	Date

PRACTICE POLICIES

Our goal is to provide quality dental care in a timely manner. In order to do so we have had to implement a cancellation and no show policy. The policy enables us to better utilize available appointments for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT
In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. We ask that you give us a call 24 hours in advance or this may result in a $45.00 fee.

NO SHOW POLICY
A "no show" is an appointment that was not canceled in advance. No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will result in a fee of $45.00.

LATE ARRIVALS
In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call the office. If you are more than 10 minutes late to your scheduled appointment, you may be asked to reschedule.

CELL PHONE POLICY
As a courtesy to other patients and in effort to maintain our schedule, we request that cell phones be put away while the doctor, hygienist, assistants is in the room with you.

I have read and understand the "Practice Policies".

_____	_____	_____
Patient's Name (Printed)	Patient's Signature	Date

HIPAA COMPLILANCE FORM

Patient Information:

Name: _____ Date of Birth: _____

I request that the following be allowed for the disclosure of my protected Health Information. Protected Health Information would include: name, diagnosis, test results, and dates of service.

You may disclose information to my family members or non-family members.

Please list the name, phone number and relationship:

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Our office reserves the right to e-mail x-rays and records to other dental/medical facilities and insurance companies. Our office also has the capability of text messaging and emailing information regarding your dental appointment.

Acknowledgement of receipt of privacy practice notice

I acknowledge that I have received a Notice of Privacy practices from Shambaugh Dental Group. I attest that the above information is correct.

Signature: _____ Date: _____

Printed name:_____ Relationship if patient is child: _____

** For Office Use Only **

Describe your good faith effort to obtain the individual's signature, and reason why the individual would not sign the form:

_____

_____