WELCOME

PATIENT INFORMATION

Date _____ SS # _____

Patient First Name _____ MI _____

Patient Last Name _____

Address _____

_____
City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation _____

Employer _____

Employer Address _____

_____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Who is responsible for this account? _____
(If patient is a minor, the parent/guardian accompanying child)

Relationship to Patient _____

Phone _____

DENTAL INSURANCE

Primary Subscriber's Name _____

SS# of Insured _____ ID# _____

Employer _____

Ins. Co. _____ Phone _____

Ins. Address _____

_____

Secondary Subscriber's Name _____

SS# of Insured _____ ID# _____

Employer _____

Ins. Co. _____ Phone _____

Ins. Address _____

_____

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Dr. Jeffrey D. Shawberry all insurance benefits, if any, otherwise payable to me for services rendered. I hearby authorize the doctor to release all information necessary to ensure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

_____
Responsible Party Signature Relationship Date

PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext. _____ Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in your household).

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐ Yes	☐ No		Lip or cheek biting	☐ Yes	☐ No	
Bleeding gums	☐ Yes	☐ No		Loose teeth or broken fillings	☐ Yes	☐ No	
Blisters on lips or mouth	☐ Yes	☐ No		Mouth breathing	☐ Yes	☐ No	
Burning sensation on tongue	☐ Yes	☐ No		Mouth pain, brushing	☐ Yes	☐ No	
Chew on one side of mouth	☐ Yes	☐ No		Orthodontic treatment	☐ Yes	☐ No	
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No		Pain around ear	☐ Yes	☐ No	
Clicking or popping jaw	☐ Yes	☐ No		Periodontal treatment	☐ Yes	☐ No	
Dry mouth	☐ Yes	☐ No		Sensitivity to cold	☐ Yes	☐ No	
Fingernail biting	☐ Yes	☐ No		Sensitivity to hot	☐ Yes	☐ No	
Food collection between the teeth	☐ Yes	☐ No		Sensitivity to sweets	☐ Yes	☐ No	
Foreign objects	☐ Yes	☐ No		Sensitivity when biting	☐ Yes	☐ No	
Grinding teeth	☐ Yes	☐ No		Sores or growths in your mouth	☐ Yes	☐ No	
Gums swollen or tender	☐ Yes	☐ No		How often do you floss? _____			
Jaw pain or tiredness	☐ Yes	☐ No		How often do you brush? _____			

(OVER)

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as Fen-Phen? These include combinations of Ionimin, Adipex, Fastin (brand names of Phentermine), Pondimin (Fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following.

AIDS/HIV	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☑ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally with extractions or surgery	☐ Yes	☐ No	Hepatitis Type	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Tonsilitis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Do you wear contact lenses?	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Weight Loss unexplained	☐ Yes	☐ No
Parkinson's Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No			
Women:			Psychiatric Care	☐ Yes	☐ No			
Are you pregnant?	☐ Yes	☐ No						
Taking birth control pills?	☐ Yes	☐ No						

Due Date? _____ Are you Nursing? _____

MEDICATIONS

List any medications you are currently taking and the correlation diagnosis.

_____

_____

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone (___) _____

ALLERGIES

☐ Aspirin ☐ Barbiturates ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Penicillin/Amoxicillin ☐ Sulfa

☐ Other _____

_____

_____

Signature _____ **Date** _____

Jeffrey D. Shawberry, DDS, Inc.
66 Ashwood Road • Tiffin, OH 44883 • P: (419) 447-1851 • Fax: (419) 447-0397

PATIENT POLICIES

We truly appreciate you entrusting us with your dental health. As an office and staff, we pride ourselves on delivering the highest quality care and level of service to our patients. We need your help. To achieve our goals we have outlined specific cancellation and financial policies. It is important that you know and understand these so we can serve you and all our patients to the best of our ability.

Cancellation Policy

An appointment in our office is reserved specifically for you and the doctor or hygienist. To give full attention to you, we do not "double book" our schedule. We also leave room in our schedule for "emergency" patients who have urgent needs. Leaving this open space will create minimal impact on patients who have reserved an appointment.

- If you are unable to make your reserved time, we ask you to call our office during business hours at least 2 business days (48 hours) in advance.
- A "no-show" appointment is simply one where the patient does not call our office or leave a message in accordance with the above guideline.
- On the first no-show appointment you will be charged a cancellation fee of $25.
- After two no-show appointments, you may be dismissed from the practice.
- If you are running late for an appointment, we ask that you call us to keep us informed. This will allow our schedule to flow as smoothly as possible. We will do all we can to adjust our schedule to get you in for service. Our scheduling coordinator will work with you as needed.

Financial Policy

We gladly submit your insurance claims to your insurance company as a courtesy to you. Your insurance policy is a contract between you, your employer, and your insurance company. It is the responsibility of the patient to notify this office of any changes to name, address, phone number and employer. If insurance has changed, it is the responsibility of the patient to present the new insurance card and information at the time of visit. ***Payment is required at the time of service for all charges not covered by your insurance company including co-pay and deductibles.***

I agree that I will be responsible to pay for any portion of the charges not covered by my insurance. If I fail to pay the outstanding balance within thirty (30) days of the due date, I understand that my obligation my be referred to a third-party collection agency and that I will be responsible for any collection fees, interest, and other expenses necessary to collect on my account, including court costs, should legal action be instituted against me.

I have read, understand and agree to the above cancellation and financial policies.

Patient Signature	Printed Name	Date

ACKNOWLEDGMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have had a chance to review a copy of the Statement of Privacy Practices (located in the practice waiting room) for the office of Jeffrey D. Shawberry, D.D.S. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

Jeffrey D. Shawberry, D.D.S. reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hearby specifically authorize disclosure of my protected health care information to the persons indicated below.

- ❑ ANY MEMBER OF MY IMMEDIATE FAMILY
- ❑ SPOUSE ONLY
- ❑ OTHER (Please specify) _____

_____ _____

Name of Patient or Personal Representative Date

_____

Description of Representatives Authority

_____

Representatives Phone Number

Jeffrey D. Shawberry, D.D.S., Inc.