Patient Information

We are pleased to welcome you to our office. Please take a few minutes to fill out this form. If you have any questions, we will be glad to assist you.

Personal

Name: _____

Last First MI (preferred)

Birthdate: _____ SS#: _____ Gender: M or F

Work Ph: _____ Cell Ph: _____

What is your preferred contact method: Call Text Email

May we text/email appointment confirmations and communication: Y OR N

Email: _____

Address

Is the address the same for the entire family: Y OR N

Address: _____

City: _____ State: _____ Zip Code: _____

Home Ph: _____

Insurance Policy 1

Your Relationship to Subscriber: Self Spouse Child

Subscriber Name: _____ Subscriber Id: _____

Insurance Company: _____ Insurance Ph: _____

Employer: _____ Group Name: _____

Group #: _____

Insurance Policy 2

Your Relationship to Subscriber: Self Spouse Child

Subscriber Name: _____ Subscriber Id: _____

Insurance Company: _____ Insurance Ph: _____

Employer: _____ Group Name: _____

Group #: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease)_	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐

ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

_____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6) ○ ○ ○

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ___/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐

GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum disease, gum or bone loss between your teeth, or had scaling and root planing?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have a right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. Copy of Privacy Policies supplied by request.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your dental condition with any member of your family? YES NO

If yes, please name the person(s) allowed:

_____

_____

This consent was signed by _____

(Print name please)

Signature_____ Date_____

DENTAL OFFICE FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of your financial policy which we require that you read and sign prior to any treatment.

GENERAL:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications, and also any other services not directly provided by the dentist.

CONFIRMED APPOINTMENTS:

We do our part in making sure you are aware of your pending future appointments. Unless we receive confirmation in advance of 24 hours, your reserved appointment will be given to another patient.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate and filing insurance claims, which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for services, It is your responsibility to have these questions answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

Deposit Policy:

Due to the extensive amount of time our staff and doctor devote to preparing and reserving uninterrupted time for appointments over 2 hours OR over $1500.00, we require a deposit of half (50%) of the treatment fee to make your reservation. If you fail to provide 48 hours notice of cancellation this deposit will be FORFEITED. Habitual missed appointments are grounds for dismissal from the practice.

PAYMENT:

FULL PAYMENT is due at time of services. If insurance benefits apply. ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

Unpaid balance over 90 days will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with recovery of the monies due on the account.

The parties agree that in the event of a dispute over any payment or fee due to Plateau Family Dentistry by the undersigned, the Circuit Court of Cumberland County shall have exclusive jurisdiction and venue for any litigation filed.

I have read, understand, and agree to the terms and conditions of this Financial Agreement.

X_____

Date_____

RADIOGRAPH CONSENT FORM

EFFECTIVE 01/01/2020:

NEW PATIENTS (1st time at our office): I understand that I am required to have radiographs (x-rays) taken as part of a complete and thorough exam so that Dr. McShan can thoroughly diagnose any oral or dental diseases that may be present (some of which can ONLY be detected with radiographs/x-rays). Failure to accept this treatment will result in dismissal from the practice.

EXISTING PATIENTS (Patients of record): I understand that I am required to have radiographs (x-rays) taken as part of a complete and thorough exam so that Dr. McShan can thoroughly diagnose any oral or dental diseases that may be present (some of which can ONLY be detected with radiographs/x-rays) AT A MINIMUM OF EVERY 2 YEARS. Failure to accept this treatment will result in dismissal from the practice.

Please remember that your dental insurance policy is a contract between you, possibly your employer and the insurance company. This Practice is not a party to that contract and therefore cannot guarantee that any or all services will be covered. Please keep in mind that you are responsible for the total amount should your insurance benefits result in less coverage than anticipated. Before proceeding with treatment, we will provide a written estimate of fees. Although we try to get accurate information about insurance benefits and coverage before treatment, we cannot guarantee what the insurance company will pay, if anything, until the claim is submitted, and the insurance company pays the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged, whether your insurance company provides any benefits or not. Remember we do not treat according to your insurance. We treat you as an individual and care about your dental health. We are dedicated to providing the best treatment available to our patients.

By signing this you agree to the terms of the treatment proposed for you and acknowledge and agree to any financial obligations not paid for by your insurance company.

_____ _____

Patient/Guardian Signature Date

CANCELLATIONS AND CONFIRMING APPOINTMENTS

Our desire is to provide every patient with the treatment they need, along with the special attention they deserve. We do not overbook patient appointments. However, **we will DOUBLE BOOK any unconfirmed appointment.** As a courtesy to our patients, we will remind you of your appointment 7 days prior and answer any additional questions you might have. If we are unable to reach you one business day before your appointment by 2pm Monday-Thursday, it is considered an **unconfirmed appointment** and will be taken off our schedule. Please insure you have provided us with phone number(s) and/or email address(s) where we can best reach you or leave a voicemail/text-message/email during daytime hours. If you know you will be unable to keep your appointment, please call us as soon as possible.

So that we can accommodate all our patients needs, we ask that you provide us 24 hours notification if you are unable to keep a scheduled appointment.

We do understand that circumstances do arise that are beyond your control. **For patients who consistently break appointments without 24 hours' notice and/or after having confirmed their appointments, we do reserve the right to no longer see you in our practice.** The decision to terminate/fire a patient will be determined on a case-by-case basis and the patient will be notified in writing.

I understand the policy for broken and/or unconfirmed appointments whereby I have not provided a 24-hour notification for a cancellation.

_____ _____

Patient or Guardian Signature Date