Shabo Dental
Smile Studio

We create unforgettable smiles!

Patient's Name _____ Date _____

Address _____ Home Phone ( )_____

City/State/ZIP_____ Work Phone ( )_____

Cell Phone ( )_____ E-Mail Address _____

Patient's Social Security # _____ Date of Birth _____

Employer _____

Dental Insurance Carrier _____ Pharmacy_____

If your Insurance is NOT carried through YOUR place of employment, PLEASE fill out the information below!

Spouse/Guardian Name _____ Date of Birth_____

Spouse/Guardian Social Security # _____

Spouse/Guardian Employer _____ Work Phone ( )_____

Dental Insurance Carrier _____ *Subscriber ?*_____

Please present your Insurance Card with this form!

Financial Arrangements and Dental Insurance

Payment for all **RESTORATIVE PROCEDURES AND PERIO CARE** is due at the time services are rendered. We accept **Cash, Checks, MasterCard, Visa, Discover or Care Credit.** As a courtesy to you, it is our pleasure to prepare your claim to file. Our relationship is with you, the patient, not your insurance company. For **Preventive Care i**f we have not received payment from your insurance carrier within 45 days of your visit, payment will be expected from you. Balances not paid within 30 days after your first statement will be subject to a 1 1/2% (one and one-half percent) service charge per month. Attorney's fees and court cost will also be added to the outstanding balance if it becomes necessary to take legal action to collect past due amounts.

Authorized Benefits

I request that payment of authorized insurance benefits for services rendered be made to the dental care provider for any services furnished to me or on my behalf. I authorize any holder of dental information about me to release such information to my insurance company and its agents in order to determine benefits payable for related services.

I have read and understand the above financial policies for insurance, unpaid balances and authorized benefits. I understand that the charges are my responsibility.

_____ _____

Patient/Guardian Signature Date

PLEASE TURN TO BACK OF THIS SHEET TO ANSWER MEDICAL QUESTIONS

MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your condition. The information you provide will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

1. General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Are you under the care of a physician for a current problem? ☐ Yes ☐ No

   If yes, please list reason: _____

3. Are you taking any medications or drugs? ☐ Yes ☐ No

   If yes, please specify: _____

4. Please CIRCLE any of the following that you currently have or have had:

AIDS/HIV	Heart Attack	Prosthetic Implants
Artificial Heart Valve	Heart Murmur	Radiation Treatment
Asthma	Hepatitis	Rheumatic Fever
Cancer/Malignancy	High Blood Pressure	Stomach Ulcers/Colitis
Cardiovascular Disease	Kidney Disease	Stroke
Congenital Heart Disease	Liver Disease	Temporomandibular Joint Problems (TMJ)
Diabetes	Mitral Valve Prolapse	
Epilepsy or Seizures	Nervous Disorder	Tuberculosis
Fainting	Prolonged Bleeding	Venereal Disease

5. Have you had or do you have any medical problem not listed above? ☐ Yes ☐ No

   If so, please describe: _____

6. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to ***latex, anesthetics, antibiotics*** or other medications? Yes ☐ No ☐

   If yes, please list: _____

7. Have you experienced an unfavorable reaction from any previous dental treatment? Yes ☐ No ☐

   If yes, please describe: _____

FEMALES:

8. Are you pregnant or nursing? ☐ Yes ☐ No

I, the undersigned, agree that all of the above information is true to best of my knowledge;

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their guests consent for uses and disclosures of health information about the quest to carry out treatment, payment, or health care operations.

As our guest we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations. These entities are most often not required to obtain quest consent.

Patient/Guardian Signature_____ Date _____

If the patient is a minor, I give permission for examination and endodontic treatment for my minor child named above:

Payment

I agree to be and hereby am, fully responsible for total payment of procedures performed in this office or under the care of *Shabo Dental Spa,* or at another facility at which I may be treated.

If I do not have dental coverage, I understand I am responsible for the entire amount at the time of service.

Full Mouth Digital Xrays and a Comprehensive Exam are required for New Patient appointments.

Insurance Agreement

****Proof of current insurance is required to file my claim. If it is not presented at my appointment, I will be responsible for payment in full on the day of service.****

I understand my insurance contract is between myself and my insurance carrier, NOT between the insurance carrier and *Shabo Dental Spa*. And I am responsible for any insurance deductible, co-pay, and/or any amount not covered by my insurance plan. If my insurance carrier has not paid within 90 days, I understand the balance will be due and payable by me. If any reason the account is not paid in a timely manner, I understand the account will be turned over for collections and that I am responsible for all collection cost.

I assign and direct the insurance company to pay, without further notice, to *Shabo Dental Spa,* such amount as may be payable to me, I hereby authorize this office to maintain my signature on file as needed for insurance purposes.
I authorize *Shabo Dental Spa,* any information acquired in the course of their examination or treatment.

Signature _____

HIPAA Regulation Consent Form

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations: quality review and specialist consultations.

I have been informed that I may review the practice's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent.

I understand this practice has the right to change their privacy practices and I may obtain any revised notices of the practice.

I understand I have the right to request a restriction of how my protected health information is used. However, I also understand the practice is not required to agree to this request. If the practice agrees to my requested restriction, it must follow the restrictions.

I understand I may revoke this consent at any time by making a request in writing, except for information already disclosed.

Signature _____ *Date*_____

If signed by patient representative, state relationship to patient.

_____

Time Courtesy Contract

In these busy days, time really is of the essence for all of us! A 24 hour notice of cancellation is required! If notice is not received in this timely manner, a $39 surcharge will automatically be added to my account. I will be responsible for collection fees.

Please sign and date your understanding and compliance to the Time Courtesy Contract….

Signature _____ *Date*_____

Consent for Photography

I consent for *Shabo Dental Spa,* to photograph any tissue, bone, or anatomical structures for purposes of diagnosis, treatment, patient education, presentation, or medical/dental research.

Signature_____