Chart #: _____
FOR OFFICE USE ONLY

Welcome to Shelby Dental Care Center

PATIENT INFORMATION

Last Name:	First Name:	MI:	Preferred Name:
Title (Mr/Ms/Mrs/etc)	Gender: ☐ Male ☐ Female	Family Status: ☐ Married ☐ Single ☐ Child ☐ Other	
Birth Date:	SS #:	Prev. Visit:	
Email Address:		Best Time to Call:	
Home Phone:		Work Phone:	
Mobile Phone:		Fax:	
Street Address:			
City:		State:	Zip Code:

APPOINTMENT CONFIRMATION

Do we have permission to text for appointment confirmation? ☐ Yes ☐ No

I understand that this communication will not be secure and I may be charged by my wireless carrier for text messaging depending on my plan.

EMERGENCY CONTACT

Name:	
Phone Number:	Relationship to Patient:

ACCOUNT INFORMATION – PERSON ULTIMATELY RESPONSIBLE FOR THE ACCOUNT

The following is for: ☐ the patient's spouse ☐ the person responsible for the payment ☐ neither-not applicable

Last Name:	First Name:	MI:	Preferred Name:
Title (Mr/Ms/Mrs/etc)	Gender: ☐ Male ☐ Female	Family Status: ☐ Married ☐ Single ☐ Child ☐ Other	
Birth Date:		Email Address:	
Home Phone:		Work Phone:	
Mobile Phone:		Best Time to Call:	
Street Address:			
City:		State:	Zip Code:

PATIENT'S EMPLOYMENT INFORMATION

The following is for: ☐ the patient	☐ the person responsible for payment	
Employer Name:		Phone:
Street Address:		
City:	State:	Zip Code:

SHELBY DENTAL CARE CENTER

139 West Ross Grove Road • Shelby, NC 28150
P: 704-482-7986 • F: 704-480-9301
shelbydentalcarecenter.com

Revised: 08/14

PRIMARY INSURANCE INFORMATION

Last Name of Insured:	First Name:	MI:
Insured's Birth Date:	ID #:	Group #:
Insured's Street Address:		
City:	State:	Zip Code:
Insured's Employer Name:		
Employer Street Address:		
City:	State:	Zip Code:
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Insurance Plan Name:		
Insurance Street Address:		
City:	State:	Zip Code:

SECONDARY INSURANCE INFORMATION

Insured's Birth Date:	ID #:	Group #:
Insured's Street Address:		
City:	State:	Zip Code:
Insured's Employer Name:		
Employer Street Address:		
City:	State:	Zip Code:
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Insurance Plan Name:		
Insurance Street Address:		
City:	State:	Zip Code:

INSURANCE AUTHORIZATION

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

MEDICAL HISTORY

Indicate which of the following conditions you have or have had:

- ☐ Alcohol Abuse
- ☐ Allergy – Latex
- ☐ Cancer
- ☐ Drug Abuse
- ☐ Hepatitis
- ☐ Knee Replacement
- ☐ Pregnancy
- ☐ Back Problems
- ☐ Arthritis
- ☐ Emphysema
- ☐ Diabetes
- ☐ Low Blood Pressure
- ☐ Jaw Problems
- ☐ Leukemia
- ☐ Rheumatic Fever
- ☐ Severe Headaches
- ☐ Stomach Ulcers
- ☐ Venereal Disease
- ☐ Allergy – Ibuprofen
- ☐ Autoimmune Disorder
- ☐ Chemo/Radiation
- ☐ Heart Attack
- ☐ Hip Replacement
- ☐ Mental Impairment
- ☐ PreMed Dental Tx
- ☐ Congenital Heart Defect
- ☐ Cosmetic Surgery
- ☐ Asthma
- ☐ Hypoglycemia
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Mitral Valve Prolapse
- ☐ Respiratory Problems
- ☐ Shingles
- ☐ Thyroid Problems
- ☐ Seizures
- ☐ Allergy - Penicillin
- ☐ Blood Thinners
- ☐ Dialysis
- ☐ Hemophiliac/Bleeding
- ☐ HIV
- ☐ Organ Transplant
- ☐ Stroke
- ☐ Difficulty Breathing
- ☐ Anemia
- ☐ Chest Pains
- ☐ Fainting
- ☐ Pacemaker
- ☐ Liver Problems
- ☐ Psychiatric Problems
- ☐ Scarlet Fever
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Epilepsy

List any medical conditions that you have that were not listed above:

PRE MED: Do you take antibiotic premedication for your dental visits? If yes, please explain and give medication and dosage information below:

List any allergies that you have:

List any medications that you are taking:

Surgeries- List the type of surgery and the date it was complete:

Are you under care of Pain Management? ☐ Yes ☐ No	Pain Management Physician's Name and Phone Number:
	List Pain Management Medications:

PREGNANCY

Are you pregnant? ☐ Yes ☐ No	What is Your Expected due Date?	Did you Bring Clearance From Your OB/GYN for Dental Treatment? ☐ Yes ☐ No
☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.		

DENTAL HISTORY

Previous Dentist Name:	Date of Most Recent Dental Exam:
What is Your Immediate Concern?	Date of Most Recent Dental X-Rays:

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information, and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered, as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times,during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Name of patient, parent or guardian completing this form:			Response Date:	
Relationship to Patient: ☐ Self	☐ Parent	☐ Guardian	☐ Spouse	☐ Other

CONSENT FOR SERVICES AND FINANCIAL POLICY

In our office, you have a variety of financial options from which to choose.

The office accepts the following forms of payments:

- Cash
- Personal checks with photo identification. There is a $25 charge for returned checks.
- Visa, MasterCard, and American Express

Patient With Insurance:

- The patient's estimated portion is due at the time of service. Please do not ask us to bill you.
- Insurance claims are filed as a courtesy at no charge to the patient.

Regardless of pending insurance reimbursement or preauthorization, the patient is responsible for payment in full within 60 days of service. A service charge of 1.5% (18% annual) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collection from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Patients Without Insurance:

- We offer a 6% courtesy discount on treatment of $500.00 or more that is paid in full prior to or at the lime of the first treatment appointment.
- In cases that involve a limited course of treatment, it is possible to pay a percentage of the total fee on the day of initial treatment, with the balance paid in subsequent payments that are due on the day(s) when active treatment is scheduled. The Treatment Coordinator will discuss these payment options with you.

Extended Payment Plan:

- For patients who wish to pay for treatment in smaller amounts over an extended period of time, we offer a flexible payment pain that is administered by Care Credit, an independent company. This independent dental financial company offers a revolving line of credit to qualified patients and there is no penalty for early payment and will honor 90 days same as cash with no interest. The Treatment Coordinator will provide you with all the details.

☐ By checking this box. I understand the above information and agree with the contents. This will serve as my electronic signature for the Administration Form.