Shambaugh & Hertig
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 SSN _____Insured's Employer: _____

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 & HERTIG 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 & HERTIG 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 & HERTIG 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 & Hertig
DENTAL GROUP

Insurance Release and Financial Policy

I certify that I have read and I understand the questions about my health history. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff responsible for any errors or omissions that I have made in the completing of this form.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Shambaugh & Hertig Dental Group to provide medical/dental evaluation, care, and/or treatment to me or someone I am authorized to make medical decisions for. This evaluation, care, or treatment is considered medically necessary and proper in the diagnosing or treatment of his/her/my physical condition. I understand that even though I give my consent for evaluation, care, or treatment, I may refuse any of these services at any time.

FINANCIAL POLICY STATEMENT

In consideration for services rendered and to be rendered by Shambaugh & Hertig Dental Group to the patient named below, I (we) agree to pay Shambaugh & Hertig Dental Group for all services and charges as are ordered by the attending doctor. We will file your insurance claim as a courtesy to you; however, we cannot guarantee coverage and will only supply an estimation of benefits. Final payment determination will come from your insurance plan documents.

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

CANCELLATION POLICY

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 fee.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize to my insurance company release of all information necessary for the payment of benefits. I hereby assign payment of benefits by my insurance company to Shambaugh & Hertig Dental Group.

I am giving consent for release of minimal health information or financial information to the following individuals:

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ I further authorize Shambaugh & Hertig Dental Group to communicate with me electronically through text message and the e-mail address provided. I understand that this text/e-mail communication is not secured by encryption therefore is not considered a secured or private communication.

_____ _____

Patient/Guardian (18 and over) Date

_____ _____

Signature of Financially Responsible Party (Parent or Guarantor) Date