Erin A. Shiveler, DMD
Family & Cosmetic Dentistry

Patient Information

Last Name _____ First Name _____ Middle _____

Date of Birth _____ Occupation _____ Employer _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Address _____ City/State/Zip _____

Email Address _____ Marital Status: O Married O Single O Divorced O Minor

Parent or Guardian if under the age of 18 : _____ Phone: _____

Who may we thank for referring you? _____

Dental Insurance

Primary Dental Insurance Company _____

Member or Subscriber ID _____ Group Number _____

Policy Holder Name _____ Date of Birth _____

Is the insurance through the employer? Please circle: Yes No Employer _____

Dental History

Reason for today's visit: _____ Date of last dental visit _____

Previous Dentist _____ Date of last dental x-rays _____

Phone Number _____

Please indicate if you have or have had any of the following:

___ Bad Breath	___Grinding Teeth	___Sensitivity to Hot
___Bleeding Gums	___Loose teeth or broken fillings	___Sensitivity to sweets
___Clicking or popping jaw	___Periodontal Treatment	___Sensitivity when Biting
___Food collection between teeth	___Sensitivity to cold	___Oral sores or growth

Please see reverse side

Medical History

Please list all surgeries, serious illnesses or overnight hospitalizations:

If yes, please describe: _____

_____

Have you ever had a blood transfusion? Yes No If yes, approximately when?_____

***For women, are you pregnant or nursing? Please circle: Yes No

Please indicate if you have had any of the following:

___ Anemia	___Chemotherapy	___Hemophilia	
___Anxiety/Depression	___Circulatory Problems	___Hepatitis	___Respiratory Disease
___Acid Reflux/GERD	___ Cortisone Treatments	___High Blood Pressure	___Shortness of Breath
___Arthritis	___ Cough, Persistent	___HIV/AIDS	___Smoking /Tobacco Use
___Artificial Joints / Heart Valves	___Diabetes	___Jaw Pain	___Stroke
___Asthma	___Epilepsy	___ Kidney Disease	___Swelling of feet / ankles
___Back Problems	___Fainting	___Liver Disease	___Thyroid Problems
___Blood Disease	___Glaucoma	___Mitral Valve Prolapse	___Tonsillitis
___Cancer	___Headaches	___Osteopenia / Osteoporosis	___Tuberculosis
___Chemical Dependency	___Heart Murmur	___Pacemaker	___Ulcer
___Cholesterol Level Elevation	___Heart Problems	___Radiation Treatment	___Venereal Disease

List all medications, vitamins and supplements:

_____

_____

_____

Allergies:_____

_____

_____

_____

Authorization: I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his / her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his / her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature_____ **Date**_____

Relationship to Patient, if minor_____

Doctor Signature_____

OFFICE AND FINANCIAL SERVICE AGREEMENT

Our goal is to provide you with financial information related to your services today. **Please note: It is your responsibility as the patient to understand your insurance benefits.**

Payment Policy:
Payment is expected at time of service. We accept cash, personal checks, debit cards, Visa, MasterCard, American Express, and Discover.

Returned Check Fee:
Checks returned to our office from your financial institution are subject to a $40.00 return check fee. This fee covers processing fees that are charged to our office. This fee must be paid by cash or credit card only.

Insurance:
As a courtesy to our patients, we accept most major dental insurance plans. It is important for you to know that even if you are covered by dental insurance; our professional services are rendered to you, and not your insurance company. We will bill your dental insurance company for services rendered on your behalf. We will collect any known or estimated co-payments, co-insurance, or deductibles at the time of service. Additionally, the responsible party will be billed for services rendered should the insurance deny coverage due to non-covered benefits, limited coverage, waiting periods, alternate benefit downgrade or eligibility. We do our best in gathering this information for you, but your insurance determines final benefits and eligibility once a claim for services is received. After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 30 days of the statement date.

Appointments:
An appointment is confirmed the day you reserve your appointment time. We do our best to provide courtesy reminders with calls or emails, but ultimately it is your responsibility to remember your appointment. A minimum fee of $35.00 will be added for failed or cancelled appointments without 24 hour prior notification. This fee only covers a portion of overhead which still has to be paid whether you are present or not. Multiple no shows may result in dismissal from our practice.

Late Arrival:
Our office makes every attempt to remain on schedule throughout the day. A late arrival can cause scheduling delays for those patients that arrive promptly to their appointment time. A late arrival of 15 minutes or more may result in the rescheduling of your appointment.

Policy Regarding Minor Patients:
Patients under the age of 18 must be accompanied by a parent, legal guardian, or someone appointed by the parent or legal guardian with a notarized Power of Attorney form on file with our office.

Collection Activity:
Any account balances that are not paid by 90 days from date of service may be forwarded to Credit Collections USA. If deemed necessary, Erin A. Shiveler, DMD reserves the right to forward the account balance to Credit Collections USA prior to 90 days from the service date. Should collections be necessary, a convenience fee of 33 and 1/3 percent of the balance owed will be added to account balance. A convenience fee is a fee incidental to your payment obligation.

Assignment of Benefits and Release of Information:

I hereby assign to Erin A. Shiveler DMD, all benefits for dental expenses. I hereby agree to pay any and all charges that exceed or that are not covered by my dental insurance. I authorize provider named above to release dental records and medical information requested by my insurance.

Patient/Responsible Party Signature:_____ **Date:**_____

Please Print Name_____ **Date of Birth**_____

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and/or indirectly.
- Obtain payment from third party payers such as insurance companies.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the opportunity to review the Notice of Privacy Practices prior to signing this consent. I also understand that this office has the right to change its' Notice of Privacy Practices from time to time and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

I understand that this office has an "open-bay" floor plan and that there is the possibility that some conversations may be overheard. We will take every precaution to prevent this from occurring.

I understand that I may request, in writing, that you restrict how my information is used or disclosed. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions. I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this request.

PATIENT
NAME (Print) _____ Birthdate_____

Signature_____

Relationship to patient_____ Date_____

Erin A. Shiveler, DMD
Family & Cosmetic Dentistry

Release of Information Authorization

I, _____, give the following individual(s) permission to obtain the following information regarding my care at this office:

____Dental Treatment ____Billing and Insurance ____Medical History

_____ _____

Print Name Relationship to Patient

_____ _____

Print Name Relationship to Patient

_____ _____

Print Name Relationship to Patient

_____ _____

Patients Signature Date

_____

Witness

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