PATIENT INFORMATION FORM

Date_____ Name:_____

Address_____ City_____ State____ Zip_____

Home#_____ Work_____ Cell_____ Email_____

Employer_____ Occupation_____

SS#_____ Birthdate_____ Drivers Lic_____

Spouse's Name_____ Phone#_____

Emergency Contact_____ Phone#_____

Whom may we thank for referring you to our office?_____

PERSON RESPONSIBLE FOR PAYMENT

Name_____ Relationship to patient_____

Address_____

Employer_____ Occupation_____

Home#_____ Work_____ Cell_____

SS#_____ Birthdate_____ Drivers Lic_____

DENTAL INSURANCE INFORMATION

Primary Insurance Co._____ Phone#_____

Subscriber Name_____ SS#_____ Birthdate_____

Employer/Grp Name_____ Group#_____

Member/Suscriber ID#_____ Secondary Ins_____

MEDICAL HISTORY

PATIENT NAME_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No O N/A_____

Have you ever been hospitalized or had a major operation? O Yes O No O N/A_____

Have you ever had a serious head or neck injury? O Yes O No O N/A_____

Are you taking any medications, pills, or drugs? O Yes O No O N/A_____

Do you take, or have you taken, Phen-Fen or Redux ? O Yes O No O N/A Do you use tobacco? O Yes O No O N/A

Are you on a special diet? O Yes O No O N/A Do you use controlled substances? O Yes O No O N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptive?

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other_____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain In Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsilitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? O Yes O No O N/A _____

Comments: _____

_____

_____

*Condition may require medication N/A - Not answered by patient

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

DENTAL HISTORY

Do you have a dental complaint at this time? _____

What was the date of your last dental treatment? _____

How often did you see your dentist? _____

Have you ever had an unpleasant dental experience? _____

Who was your last dentist and where? _____

Do you grind or clench your teeth? Yes No

Do you have pain in your jaw joint? Yes No

Do you have sore or sensitive teeth? Yes No

Do your gums bleed? Yes No

Do you get cold or canker sores? Yes No

Do you have an unpleasant taste in your mouth? Yes No

Do you have frequent headaches? Yes No

Do you have ear aches? Yes No

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you have any: Loose____ Cracked____ Broken teeth____? Check all that apply

Have you had periodontal treatment? _____

Have you ever worn braces? _____ When? _____Dr's name: _____

Do you have any missing teeth? _____Have they been replaced? _____

If so how? Fixed bridge____ Removable partial____ Denture____ Implant ____

How do you feel about the appearance of your smile? _____

Would you be interested in whiter teeth? _____ , or cosmetic dentistry to improve your smile? ____

Name of spouse or parents _____

Work place of spouse _____phone number _____

Whom should we contact in case of an emergency? _____

Who may we thank for referring you to our office? _____

Notice of Privacy Practices Acknowledgement

Stephen Shannon, DDS
13354 Coursey Blvd
Baton Rouge, LA 70816

I understand that under the Health Insurance Portability and 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 the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a copy of The Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to patient:_____

Signature:_____

Date:_____

(Office use only) I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____

Stephen P. Shannon, DDS
13354 Coursey Blvd.
Baton Rouge, LA 70816

Financial Information

Below is our financial policy, which includes all options for payment on any treatment received from Dr. Stephen Shannon. We want to make your dental experience the most comfortable in every way we can. Please read and sign below that you have read and understand our financial policy.

- Insurance is accepted on assignment and as a ***COURTESY***, our office will file your claim and initiate correspondence. However, if insurance has not paid within 30 days of treatment the balance is due and payable by you, the patient. Patients are expected to pay, on the day of service, that portion of the total fee not covered by their insurance. This "patient portion" is ***ONLY*** an estimated dollar amount.
- Cash /Checks are accepted by per appointment needs.
- Visa/Mastercard/Discover/Amx are accepted for payment.
- Short Term payment arrangements can be made through us.
- Extended payment arrangements may be made through a Health Care Financing Program with- no interest options available.

All NSF checks will be charged a $25 fee and any account with a balance 60 days past due or more will be have a finance charge posted per month of 1.50%.

As a courtesy to other patients that may be on a treatment waiting list please give us a *24 hour* notice should you have a schedule change with your appointment. Failure to do so may result in a $25 cancellation charge.

Signature: _____ Date: _____

The benefits of a happy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Stephen P. Shannon, D.D.S
13354 Coursey Blvd.
Baton Rouge, LA 70816

Consent For Treatment

1. I hereby authorize doctor or designed staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____

Parent/Responsible Party's Signature _____

Relationship to Patient_____