Personal Information and Health History

Date: ____________________
Name: ______________________________ SS# ____________________________
Address: ____ Birthdate: ____________
City: ____________________________ State: _____________ Zipcode: _________
Home Phone: ______________ Work Phone: ____________ Cellphone: __________
Email Address: (1) _______________________ (2) _____________________________
Spouse Name: ___________________________ Spouse SS#: _____________________
Occupation: ____________________________ Employer: _________________________
Person Responsible For This Account: ____
Do you have dental insurance? [] Yes [] No Insurance Subscriber__________________
Subscriber D.O.B.________________Subscriber SS # ____________________________
Dental Insurance Company: ________________________ Policy # _________________

I consider myself to be in [] Excellent [] Good [] Fair [] Poor Health.
My last examination by my physician was (Date) ____________________
Physician's Name and Phone # ____

Who may we thank for referring you to our office:________________________________

Please tell us about your health. Have you had or do you have now…….

Heart Disease	[] Yes [] No	Scarlet Fever	[] Yes [] No
High Blood Pressure	[] Yes [] No	Stomach Ulcers	[] Yes [] No
Fainting Spells	[] Yes [] No	Persistent Cough	[] Yes [] No
Hives or Skin Rash	[] Yes [] No	Tuberculosis	[] Yes [] No
Arthritis	[] Yes [] No	Epilepsy	[] Yes [] No
Asthma	[] Yes [] No	Hepatitis	[] A [] B [] C
Stroke	[] Yes [] No	Cancer	[] Yes [] No
Anemia	[] Yes [] No	Kidney Trouble	[] Yes [] No
Glaucoma	[] Yes [] No	Venereal Disease	[] Yes [] No
Hearing Loss	[] Yes [] No	Positive HIV or ARC	[] Yes [] No
Herpes	[] Yes [] No	Multiple Sclerosis	[] Yes [] No
Diabetes	[] Yes [] No	Epstein-Barr	[] Yes [] No
Sjogrens Syndrome	[] Yes [] No	Celiac Disease	[] Yes [] No

Please tell us what you are allergic to or have reacted to………..

Local Anesthetic	[] Yes [] No	Latex	[] Yes [] No
Penicillin	[] Yes [] No	Gluten	[] Yes [] No
Sulfa	[] Yes [] No	Sedatives	[] Yes [] No
Aspirin	[] Yes [] No	Iodine	[] Yes [] No
Codeine	[] Yes [] No	Acetaminophen	[] Yes [] No
Ibuprophen (Advil)	[] Yes [] No	Valium	[] Yes [] No
Tetracycline	[] Yes [] No	Halcion	[] Yes [] No
Erythromycin	[] Yes [] No	Which Foods	______________________

Please list all current medications that you are taking:

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____

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Do you have or wear any of the following:

Pacemaker []	Shunt []
Replacement Heart Valve []	Artificial Joint []
Heart Bypass []	Contact Lens []
Hearing Aid []	Organ Replacement []

Please tell us if any of the following apply to you:

Pregnant Now [] Yes [] No
Currently undergoing Radiation or Chemotherapy [] Yes [] No
Serious difficulty with previous dental work [] Yes [] No
Abnormal bleeding after dental or medical procedures [] Yes [] No
Snore often and/or loudly [] Yes [] No
Do you sleep through the night [] I do [] I don't

PRE-CLINICAL EXAMINATION QUESTIONNAIRE

1. What would you like to occur today during your appointment with Dr. Shoup?
   ____
2. I am most comfortable during my dental appointment when: ______________________________
   ____
3. I would like to know more about: **Dr. Shoup**_____ **Less Invasive Dentistry**: ___________________
   Cavity Prevention____ **Biomimetic Dentistry**______ **Microscope Dentistry**_______ **Other**______
4. I really enjoy my dental appointment when:____
5. The most important aspect of my dental health for me is: ___________________________________
6. How often do you have your teeth cleaned (prophylaxis)? ________ Flossing Habits____________
7. Do you use an electric toothbrush? ______________ Brand: ________
8. Describe your brushing habits? ______________________ At home care routine? ___________
9. I am interested in improving the color, appearance, function of my teeth with: whitening_______
   Orthodontics____ Cosmetic Restorations_______ Other?_________________________________
10. Have you noticed any changes in your oral health such as bleeding, inflammation, tenderness, irritation, taste or bad/unpleasant breath?____ When ?______Expected cause?_________________________
11. Do you avoid any part of your mouth while brushing? ___ _______Reason?____________________
12. Have you been diagnosed with any bone loss? ________When?____ Treatment?__________________
13. Do you have missing teeth? _________Would you like to explore replacement? _________________
14. When chewing, do you chew only on one side? _______Which side do you avoid?________
    Reason ____
15. Does food catch between teeth? __ If so, where?__ Would you like to improve this?_______________
16. Do you experience aches or pain in the side of your face, neck, ears or head? _______________
    Describe pain and treatment explored:____
17. Are you subject to chronic headaches? ____________Treatment?___________________________
18. Do you clench your teeth? ___________Day________Night_______Both____________Night guard?
    ____
19. I would like to explore this today: ____

Insurance Information

Patient name:_______________________________________ DOB:__________________________

If insurance subscriber is not the patient, please provide the subscriber's name and DOB

Subscriber name:_________________________________ Subscriber DOB:_____________________

Name of insurance co: ____

Phone # of insurance co:____

Address to mail claims:____

State:_________________________ Zip____

ID #:____________________________________ Group #____________________________________

Payor ID:___________________ Max: $___________________ Ded:$_____________________

Calendar year OR Fiscal year (If Fiscal year please get the dates the year begins)

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Health Insurance Portability and Accountability Act
HIPAA

Consent

I give this practice my consent to use or disclose protected health information regarding myself and/or family members to carry out my/our treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

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

I understand that this practice has the right to change their privacy practices and that I/we may obtain any revised notice at the practice.

I understand that I/we have the right to request a restriction of how my/our protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my/our requested restriction, they must follow the restriction(s).

I also understand that I/we may revoke this consent at any time, by making the request in writing, except for information already used or disclosed.

Signature:____ Date:______________
Patient or legal guardian

Names of family members:____

____

Microscope Dentistry by Shoup
Randolph K. Shoup, D.D.S.
14540 Prairie Lakes Dr. N. Suite 205
Noblesville, IN 46060

Microscope Dentistry by Shoup
Randy Shoup, D.D.S.
14540 Prairie Lakes Blvd. N. Suite 205
Noblesville, IN 46060

Financial Agreement

1. Our relationship with you is based on your treatment and the total fee for your treatment. We will work together to create an appropriate payment program for you based on your needs and the total fee of treatment. We accept cash, checks, or major credit cards.

2. We will assist you in filing your insurance claims. You are responsible for providing us with the correct insurance information, including name of employer, group number, subscriber's social security number, and a toll free telephone number to contact the insurance carrier.

3. If you desire additional information about your insurance coverage, it is your responsibility to obtain whatever information you want directly from your insurance carrier or your human resources contact person. We recommend using the toll free customer service number listed on your insurance card.

4. Payment in full at the time of service is our preferred method of payment. We provide a variety of payment options if needed. If you need information on our financial options our financial coordinator can discuss these options with you.

5. Our financial relationship with you is based on the total fee for your treatment. You are responsible for the total fee of treatment even if your insurance denies, rejects, downgrades or in any way does not compensate you for what you feel is the insurance's responsibility to pay.

6. We have the option to apply finance charges to all balances over **60 days** from date of service.

7. Your time as well as Dr. Shoup's time is very valuable. If the need arises that you have to reschedule an appointment, please provide us with a minimum of **48 hours** notice so that we have time to contact other patients that are waiting for that time frame. We may exercise the option to asses a $50 fee for failure to notify us within a timely manner or for a missed appointment.

8. I agree to pay all collection fees, returned check fees, attorney fees, and court cost, and finance fees (if applied) incurred by Dr. Randolph Shoup in collection of all sums due.

Signing this document acknowledges that I have read the above information, I understand my responsibilities, and authorize Dr. Randy Shoup and/or staff members to use my credit card as outlined above.

Signature:____________________________________ Date:____________