Patient Information

Patient Name: ____ Date:_____________

Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ___________

Social Security #: ___________________________ Birthdate: ___________________________

Phone (Home): _____________ (Work): _____________ Ext:______ Mobile_______________

Email Address:__________________________________Employer:_________________________

Address: ____

Street Apartment #

____

City State Zip Code

Please check if you have been diagnosed with or consume the following:

- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Cancer**
- ☐ **Celiac Disease**
- ☐ **Diabetes**
- ☐ **Epilepsy**
- ☐ **Epstein-Barr**
- ☐ **Fainting Spells**
- ☐ **Glaucoma**
- ☐ **Hearing Loss**
- ☐ **Hepatitis A B C**
- ☐ **Hearing Aid**
- ☐ **Shunt**
- ☐ **Artificial Joint**
- ☐ **Contact Lens**
- ☐ **Organ Replacement**
- ☐ **Persistent Cough**
- ☐ **Positive HIV or ARC**
- ☐ **Scarlet Fever**
- ☐ **Sjogren's Syndrome**
- ☐ **Stomach Ulcers**
- ☐ **Stroke**
- ☐ **Tuberculosis**
- ☐ **Venereal Disease**
- ☐ **Reaction to Local Anesthetic**
- ☐ **Allergy to Penicillin**
- ☐ **Allergy to Sulfa**
- ☐ **Aspirin**
- ☐ **Pregnant: Y N Due ______**
- ☐ **Herpes**
- ☐ **High Blood Pressure**
- ☐ **Hives or Skin Rash**
- ☐ **Kidney Trouble**
- ☐ **Sedatives**
- ☐ **Iodine**
- ☐ **Acetaminophen**
- ☐ **Valium**
- ☐ **Halcion**
- ☐ **Food Allergies: ________________**
- ☐ **Gluten Sensitive**
- ☐ **Snoring**
- ☐ **Sleep Apnea**
- ☐ **Pacemaker**
- ☐ **Replacement Heart Valve**
- ☐ **Heart Bypass**
- ☐ **Multiple Sclerosis**
- ☐ **Latex**
- ☐ **Lyme Disease**
- ☐ **Other__________________________**
- ☐ **Other __________________________**

- Are you currently undergoing radiation or chemotherapy treatment? ☐ Yes ☐ No
- Have you experienced serious difficulty with previous dental work? ☐ Yes ☐ No
  If yes, please explain:____
- Have you experienced abnormal bleeding after dental or medical procedures? ☐ Yes ☐ No
  If yes, please explain:____
- Do you snore often and or loudly? _____________ Do you sleep through the night? ☐ Yes ☐ No
- I consider myself to be in ___Excellent ___Good ___Fair ___Poor Health?
- My last examination by my physician was ______________________________

Physician's Name and Phone #:____

How did you learn about Microscope Dentistry/Dr. Shoup?________________________________

Insurance Information

Policy Holder's Name:____
Last First MI

Subscriber's ID #: ____________________ Group #:__________________ Subscribers DOB________________

Subscriber's Employer Name: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________________

Insurance Plan Name and Address: ____

Toll Free Number to contact member services: _______________________Max:____________ Deductible_________

Financial Agreement

We are honored you have selected **Microscope Dentistry by Shoup** as your dental healthcare provider. Thank you.

Prior to scheduling any appointment, your treatment options and fees will be fully reviewed with you. At all times, any financial arrangement is based on the total amount of your treatment regardless of any third party anticipated reimbursement. Any third party reimbursement is stated solely as an estimate only, not a guarantee of payment or coverage nor are services rendered on the assumption of our charges being reimbursed by any third party.

We are pleased to file your dental claims electronically including any narratives, photos or x-rays when furnished with your current dental plan information by completing the insurance information stated above. If you desire additional information regarding your insurance coverage, please contact the subscriber's Human Resources department or member services for your insurance plan. I grant my permission to have my dental insurance benefits paid directly to Microscope Dentistry by Shoup at any time I have an account balance.

I agree to make full payment at the time of service unless previous financial arrangements have been made. I acknowledge I may be charged a finance charge for any balance 60 days or older if it is not secured with a financial agreement.

I agree to pay all collection fees, returned check fees, attorney fees and court costs including any applied finance fees incurred by Microscope Dentistry by Shoup in collection of any and all sums dues.

HIPAA (Health Insurance Portability and Accountability Act 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.
Names of family members: ____

____

I have read the above condition of treatment and payment as well as the HIPAA consent. I agree to their content by my signature below.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. When there is any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: __________________
Signature of patient, parent or guardian

Relationship to Patient: Self Parent/Guardian

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: ____

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:______________