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**
- ☐ **Dry Mouth_____**
- ☐ **Acid Reflux_____**
- ☐ **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** **Spouse** **Other**