Sheppard Dental, LLC

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183 County Road 12 | Suite 500 • Odenville, AL 35120 (205)629-3099

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency, who should be notified? Please enter name, phone number and relationship below

_____

_____

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

_____

_____

Employer Name

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Subscriber and/or Parent/Guardian Information

This ONLY needs to be filled out if the insurance subscriber is other than the patient AND/OR you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ _____ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ Acid Reflux	☐ Allergy - Latex	☐ Anemia	☐ Anxiety
☐ Arthritis/Rheumatism	☐ Artifical Heart Valv	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Blood Pressure-High	☐ Blood Pressure-Low	☐ Blood thinners
☐ Cancer	☐ Chemotherapy	☐ Chest pain/angina	☐ Cortisone Medication
☐ Defibrillator	☐ Depression	☐ Diabetes	☐ Eating Disorder
☐ Epilepsy/Seizures	☐ Excessive Bleeding	☐ Fainting/Dizziness	☐ Fibromyalgia
☐ Glaucoma	☐ Gum treatment	☐ Head Injuries	☐ Headaches
☐ Hearing Impaired	☐ Heart attack	☐ Heart condition	☐ Heart Disease
☐ Heart Murmur	☐ Heart Stents	☐ Heart Surgery	☐ Hepatitis
☐ HIV/AIDS	☐ Infect. Endocarditis	☐ Insomnia	☐ Kidney Disease
☐ Liver Disease	☐ Lupus	☐ Med Allergies	☐ Mitral Valve Prolaps
☐ Morning Headaches	☐ Nightime urination	☐ Organ Transplant	☐ Osteoporosis
☐ Pacemaker	☐ Pre-Medicate	☐ Radiation Treatment	☐ Respiratory Problems
☐ Restless Leg Syndrom	☐ Rheumatic Fever	☐ Sinus/Hay Fever	☐ Sleep Apnea
☐ Stomach Problems	☐ Stroke	☐ Thyroid Problems	☐ TMJ Problems
☐ Trouble Sleeping	☐ Tuberculosis	☐ Tumors/Growths	☐ Venereal Disease
☐ Wake Frequently			

☐ Recent Hospitalization (illness or injury) ☐ Presently being treated for any other illness ☐ Tobacco/Alcohol use

☐ Pain Management ☐ Drug or Alcohol abuse ☐ Rehab Program

☐ Taking birth control ☐ Pregnant/Planning Pregnancy ☐ Nursing

If any conditions or alerts selected above needs further clarification, please describe below.

Name of physican and date of last physical exam.

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Have you been told you snore? * ◯ Yes ◯ No

Have you been diagnosed with sleep apnea? * ◯ Yes ◯ No

Do you wear (or have you worn in the past) a C-PAP or have you been told by a physician that you need to? * ◯ Yes ◯ No

Have you had a sleep study or been told you need to have one? * ◯ Yes ◯ No

Allergies and/or allergies to medications

List all medications (prescription and non-prescription), including regular dosages of aspirin.

Have you ever or are you currently taking or scheduled to begin taking any bisphosphonates (bone-building drugs), such as (but not limited to) alendronate (Fosamax), risedronate (Actonel) or ibandronate (Boniva) for osteoporosis or Paget's Disease?

◯ Yes ◯ No

Have you ever or are you currently being treated with i.v. bisphosphonates (such as, but not limited to, Aredia or Zometa) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's Disease, multiple myeloma, or metastatic cancer?

◯ Yes ◯ No

Dental Information

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist Name and Phone Number

_____

_____

Approximate date of most recent dental exam and/or dental x-rays

_____

_____

I routinely see a dentist every

◯ 3 mos ◯ 4 mos ◯ 6 mos ◯ 12 mos ◯ Not routinely

What is your immediate concern about your dental health?

_____

_____

Would you like your teeth to be whiter? ◯ Yes ◯ No

Would you like your teeth to be more straight? ◯ Yes ◯ No

Do you have missing teeth that you would like replaced? ◯ Yes ◯ No

Do you have silver fillings that you would like to be replaced with tooth-colored fillings? ◯ Yes ◯ No

If you could change anything about your smile, what would you change?

_____

_____

Check all that apply

- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Experiences dry mouth
- ☐ Avoid brushing any part of your mouth
- ☐ Whitened or bleached your teeth
- ☐ Difficulty chewing
- ☐ Currently or previously wore a bite appliance
- ☐ Diagnosed and/or treated for gum disease
- ☐ Noticed an unpleasant taste or odor in mouth
- ☐ Teeth become loose on their own (without injury)
- ☐ Snores or wakes up frequently during the night
- ☐ Had trouble getting numb
- ☐ Had/Have braces or orthodontic treatment
- ☐ Sensitive to hot, cold, biting, sweets
- ☐ Food gets trapped between any teeth
- ☐ Experienced popping and/or clicking of jaw joint
- ☐ Clenching or grinding of teeth
- ☐ Gums bleed when brushing or flossing
- ☐ Bone loss around your teeth
- ☐ Experienced gum recession
- ☐ Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

Consent for Services

I consent to be a patient at Sheppard Dental and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry, including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, dentures, and partial dentures), implant dentistry, restorative dentistry, cosmetic dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for any costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

I understand the above information and agree with its content.

☐ Yes

Office Policies

☐ **No-shows are not acceptable. Failure to make an appointment not only compromises your health, but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot keep an appointment (except in the case of an emergency) you are expected to call within 48 hours of your appointment to reschedule. There is a $100.00 fee for all no-show appointments and this fee is not covered by insurance. A portion of this fee will be donated to a charity of our choice.**

☐ **We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.**

☐ **If you miss an appointment we ask that you call to reschedule. It is critical to your health to do so to avoid setbacks in your oral health.**

☐ **Insurance: Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well-being - we are. As a courtesy we will provide you with an estimate of benefits; however you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. As a reminder, we cannot be responsible for what your insurance will or will not cover.**

☐ **We strive to run a Zero Balance office. In order to achieve this we require 50% of your total patient out of pocket expense to reserve any scheduled appointment. Please speak to a team member if you have any questions regarding financial options.**

☐ **Emergencies: It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we will provide you with the next available emergency appointment.**

I understand the above information and agree with its content.

☐ Yes

Our goal is to create an exceptional experience every time you visit our office. Please, feel free to discuss any issues that arise. No problem is too big or too small.

Photo/X-ray Waiver and Consent

I do hereby authorize and consent to the use of certain photographs/x-rays of me taken by Sheppard Dental LLC. I hereby grant them permission to reproduce, publish, print, use and distribute copies of such photographs/x-rays either in an official publication or in the form of prints, slides, or film for use in connection with articles and lectures dealing with jaw or dental disorders, or for marketing purposes in or outside the office. I specifically waive any claim for invasion of my personal privacy, which might accrue to me on account of the use of such media without my expressed consent in each instance.

NO FULL-FACE OR IDENTIFYING PHOTOS WILL BE USED WITHOUT MY EXPRESSED CONSENT.

Photography taken during treatment may be used by our laboratories for cosmetic purposes for the fabrication of crowns, bridges, dentures, or partial dentures and are part of my permanent dental record.

◯ I consent to the use of photos and x-rays as outlined above.

◯ I do not consent to the use of photos and x-rays as outlined above.

Response Date: _____