Sheerin & Wang Dentistry

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone Home: _____ Work: _____ Cell: _____ Email _____

Address: _____
Street Apartment #

_____
City State Zip Code

Person to contact in case of an emergency_____Telephone_____

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

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following conditions? Please check those that apply:

- ☐ Chest Pain
- ☐ Anemia
- ☐ Artificial Joint or Valve
- ☐ Blood Disease
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Implant/Prosthesis
- ☐ Phen Fen
- ☐ Any Allergies?
- ☐ _____
- ☐ Cancer, Tumor, Cyst
- ☐ Radiation Treatment
- ☐ Chemotherapy
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Head Injuries
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Arthritis
- ☐ Rheumatism
- ☐ Back/Spinal
- ☐ Bisphosphonate
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ Substance Abuse
- ☐ Venereal/STD
- ☐ HIV/AIDS
- ☐ Thyroid Disease
- ☐ TMJ or Facial Pain
- ☐ Are you pregnant?
- ☐ Due Date_____
- ☐ OTHER:_____

- What medications or supplements do you take? _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

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

_____ Date: _____
Signature of patient, parent or guardian

Medical History Updates:_____

_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the office will reserve the right to charge for appointments cancelled or broken without 48 hours advanced notice.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment, payment and appointments and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

MEDICATION LOG

Patient Name_____ Date of Birth_____

Date_____ Pharmacy_____ Pharmacy Phone_____
Date_____ Pharmacy_____ Pharmacy Phone_____
Date_____ Pharmacy_____ Pharmacy Phone_____
Date_____ Pharmacy_____ Pharmacy Phone_____

MEDICAL/ALLERGY ALERTS_____

Does this patient take Birth Control Pills or Patch? No_____Yes_____

Rx Date	Medication	Strength	Quantity	Frequency	Number of Refills	Condition	Refills Date/Initial.

MEDICATIONS PRESCRIBED BY OTHER PHYSICIANS

Rx Date	Medication	Strength	Quantity	Frequency	Number of Refills	Condition	Prescribing Physician

Total Health Checklist

This information will assist the dental professionals in assessing both your oral health and its impact on your overall health. Please answer completely to the best of your knowledge.

Total Health™
BEYOND THE MOUTH

Patient Name *(Last Name, First Name)* _____

Height_____ Weight_____

How frequently have you been brushing your teeth?_____

How frequently have you been flossing your teeth?_____

Do your gums bleed? ..... yes_____ no_____

Are your gums sore or swollen? ..... yes_____ no_____

Have your gums receded (do teeth look longer)? ..... yes_____ no_____

Are your teeth loose? ..... yes_____ no_____

Do you smoke or use tobacco products? ..... yes_____ no_____

Do you drink excessively? ..... yes_____ no_____

Do you have a persistent sore throat or ear pain? ..... yes_____ no_____

Do you have unexplained numbness or pain in the face/neck/mouth? ..... yes_____ no_____

Do you have a sore or lesion on the lips or mouth that has persisted for 2 weeks or more? ..... yes_____ no_____

Do you have chronic hoarseness? ..... yes_____ no_____

Do you have difficulty chewing, swallowing, or moving the jaw or tongue? ..... yes_____ no_____

Do you have a lump or thickening in the cheek? ..... yes_____ no_____

Do you snore or have you been told in the past you snore? ..... yes_____ no_____

Do you regularly have excessive daytime sleepiness? ..... yes_____ no_____

Have you been diagnosed with sleep apnea? ..... yes_____ no_____

Do you have a heart condition? ..... yes_____ no_____

Is there a history of heart disease in your immediate family? ..... yes_____ no_____

Do you have a family history of diabetes? ..... yes_____ no_____

Do you have high cholesterol? ..... yes_____ no_____

Do you have any other health conditions? ..... yes_____ no_____

FOR OFFICE USE ONLY

Record Blood Pressure _____

_____

_____

Fees and Payments

Every effort is made to keep the cost of quality dentistry affordable. We expect that all patients pay for the services at the time they receive them via cash, check, or credit card (American Express, MasterCard, Visa and Discover are all accepted). Patients with insurance benefits must pay their estimated portion at the time services are rendered. For more extensive treatment plan, we will work with your budget to make your desired dental needs affordable. Long-term financing for dental treatment is handled through CareCredit, Inc.

Insurance Benefits

Dental insurance billing is a difficult and complicated endeavor. Our office goes to great lengths to help patients receive the insurance benefits for which they are entitled.
This is our policy regarding the services we provide relative to insurance companies:

*We submit billing claims to insurance companies as a service to our patients we are not responsible for the results.

*Please remember that dental insurance is reimbursing the patient for fees already paid to the doctor, and is not a substitute for payment. Insurance is a contract between the insurance company and you, not the dentist..

*You are responsible for all charges for dental care.

Appointments

*Plan your appointments at times that you can reasonably expect to keep them.

*Because our professional team blocks out a specific time period to meet with you, it is important that you notify us at least 48 hours before your appointment if you must cancel or reschedule. Insufficient notice given to us may lead to a late cancellation charge, minimum of $100.00 per hour.

***When scheduling appointments of 2 hours or more, a deposit is required. Part or all of this deposit will be forfeited if the appointment is broken or rescheduled for any reason less than 48 hours in advance.**

*We make courtesy calls to confirm the appointment you scheduled. Please respond to our message within 24 hours.

*We want to protect the investment you are making in your oral health, it turn as part of our professional care we will recommend scheduling for periodic examinations and cleaning that is appropriate for your needs.

Please sign below that you understand and accept the policies above.

Patient name: _____ Date: _____

Patient signature: _____