Patient Information

Save some time and upload your **Photo ID or Driver's License** instead. Let's go →

HOW DID YOU HEAR ABOUT US? *

Basic Information

First Name *

Last Name *

Preferred Name

Date of Birth (MM/DD/YYYY) *

MM/DD/YYYY

Social Security #

Email Address *

Mobile Phone *

(___) ___-____

Gender *

Family Status

Family Status *

Address

Type in to search your address

Address Line 1 *

Address Line 2

City *

Country * Zip *

Contacts

Responsible Party

What is your relationship to the patient?

I am the patient | Someone else

Emergency Contact

Name

Phone

(___) ___-____

Relationship

Dental Insurance

Do you want to add your dental insurance?

Yes | No

Dental History

What is the primary reason for your visit?

Previous Dentist Name & Phone Number

When was your last dental visit/X-ray?

Have you had any unfavorable experiences?

Check if you had any problem with any ofthe following:

- [ ] Bad Breath
- [ ] Bleeding gums
- [ ] Clicking or popping jaw
- [ ] Sensitivity to sweets
- [ ] Food collection between teeth
- [ ] Grinding or clenching tooth
- [ ] Loose teeth or broken fillings
- [ ] Sensitivity when biting
- [ ] Periodontal treatment
- [ ] Sensitivity to cold
- [ ] Sensitivity to hot
- [ ] Sores or growths in mouth

How often do you brush?

How often do your floss?

Have you ever had instruction on the correct method of brushing teeth?

Have you ever had instructions on the care of your gums?

How do you feel about the appearance of your teeth and smile?

What you you like to change?

Do you take or have you taken:

- [ ] Actonel (risedronate sodium)
- [ ] Fosamax (alendronate)
- [ ] Boniva (ibandronate)

Dosage & frequency

Start date

Stop date

What medical conditions do you have?

Arthritis	Yes	No
Asthma	Yes	No
High Blood Pressure	Yes	No
HIV/AIDS	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Sinus Problems	Yes	No

Medical conditions not listed? If Yes, please list

Please add any medical conditions you don't see in the list above.

I have read, understand, and answered the questions above. I will not hold Dr. Shenk or any other member of his staff responsible for any errors or omissions that I have made in completion of this form. I authorize the release of all information my insurance company requests.

Signature *

Draw

Sign here

What allergies do you have?

Aspirin	Yes	No
Codeine	Yes	No
Latex	Yes	No
Local Anesthetics	Yes	No
Penicillin	Yes	No
Tranquilizers	Yes	No

Allergies not listed

Please add any allergies you don't see in the list above.

What medications are you taking?

Select Medications

Type or select medication

Medications not listed

Please add any medications you don't see in the list above.

Do you require premedication(such as antibiotics) before dental treatment? *

- ◯ Yes
- ◯ No

Preferred Pharmacy

Pharmacy Name

Enter Pharmacy name

Pharmacy Phone

Location

Enter Pharmacy location

Consents

Financial Policy

Shenk Dental Care IS NOT AN IN-NETWORK PROVIDER.

Patients are expected to pay their expected portion of the procedure on the date of service via check or credit card. For patients with current PPO dental insurance, we will file a claim on your behalf. Most dental insurance plans do not cover 100% of our cost of treatment. We will estimate your portion as closely as possible using the information provided by your insurance company. THIS IS AN ESTIMATE and does not constitute an exact amount. This agreement is with YOU and not your insurance company. After 60 days, the balance will be due in full. After 90 days, a finance charge of 1.5% will be applied to the remaining balance monthly.
Patients with outstanding balances over 180 days will have any upcoming appointments cancelled. Those appointments can be rescheduled once the balance has been paid in full.

Appointment Scheduling Policy

At our office, we appreciate your valuable time and reserve an adequate time slot just for you, to be able to provide you the best service. For us to keep this level of service, we ask our patients to give us a minimum of 24 hours to cancel any appointment.

Please note that late cancellations/no shows will be subject to a $75 missed appointment fee. Patients who have cancelled the same appointment 2 times may be asked to pre-pay their expected portion before rescheduling.

ELECTRONIC COMMUNICATION AGREEMENT

Shenk Dental Care may communicate with me electronically using the email and/or mobile phone information on file. All account statements will be paperless and sent via email unless requested by mail only. I can withdraw this consent at any time by calling the office at 770-992-6568

☐ By checking this box, you attest to understanding and agreeing to the above Scheduling Policy. *

Consents & Signature

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Shenk Dental Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Shenk Dental Care's Notice of Privacy Practices
provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent and receive a copy if I
so desire. Shenk Dental Care reserves the right to revise its Notice of Privacy Practices at any time.

A revised
Notice may be obtained by forwarding a written request to Shenk Dental Care at the office location.

With this consent, Dr. Shenk's office may call my home, office or other alternative location and leave a message on
voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment
reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dr. Shenk's office may mail or email to my home or other alternative location any items that assist
the practice in carrying out TPO, such as appointment reminders, insurance forms or information, and patient statements. I have the right to request Dr. Shenk's office to restrict how it uses or discloses my PHI to carry out • TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this.

By signing this form, I am consenting to Dr. Shenk's use and disclosure of my PHI to carry out TPO, I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon
my prior consent. If I do not sign this consent, or later revoke it, I understand that I will be financially responsible for any
dental work provided by this office.

Name

Relationship to Patient

Signature

By providing my signature below, I hereby consent to treatment as recommended by my provider. I attest that I have read, I understand and agree to the above Consents/Policies. This consent shall be considered in effect until rescinded or revoked. *

Draw

Sign here

FOR OFFICE USE ONLY

REVOCATION OF CONSENT
I revoke my consent for your use and disclosure of my PHI for treatment, payment activities, and healthcare operations.
I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of
Revocation. I also understand that you may decline to treat me after I have revoked my consent.

Signature

Draw

Sign here

Privacy Policy