TIME 09:21 AM DATE 5/13/2019

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

PAN/FMX HX

BW HX:

SRP HX:

NG ELIG or HX:

SEALANT HX:

WTG PERIOD:

PA'S COVERED:

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 4:04 PM | Shine Dentistry | Date 4/25/2019

Eaglesoft Medical History 11-2018

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No		
Do you use tobacco?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addicton	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

SHINE
DENTISTRY

FINANCIAL POLICY ACKNOWLEDGMENT

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We offer a variety of financial options to enable you to receive the dental care you need. We accept cash, checks, VISA, MasterCard, Discover and American Express. We have also partnered with Care Credit to offer the flexibility of deferred interest and extended payment options. If your check is returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of $25.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. Should you find it necessary to reschedule, please provide us with a notice of 2 business days. We will send you text reminders allowing you to confirm your appointment via text. Late cancellations will require a deposit to reserve the doctor's time for requested services as we have many patients to care for in a timely manner. We reserve the right to dismiss patients from our practice for chronic cancellations.

As a courtesy to our patients with dental insurance, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered.

Important Facts about your Dental Insurance

- Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.
- It is your responsibility to understand the type of dental insurance you have and the benefits selected by you and/or your employer.
- You (not the insurance company) are responsible for the fees of services rendered.

Patient/Parent/Guardian Signature: _____ Date: _____

9336 Blakeney Centre Dr Suite 100-A Charlotte, NC 28277
(704) 7598210

HIPPAA Information and Consent Form

Patient Information

Name- Last, First, MI	Date of Birth:

Information to be disclosed: verbal communication only regarding patient's care-no copies of medical records provided
Please Provide your current telephone numbers

Home Phone	Cell Phone
Work Phone	Other Phone

We normally contact our patients between 8 a.m. and 5 p.m. Monday through Friday. Please ***check below*** where you would prefer to be contacted during these hours.

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

If we need to reach you after hours, please ***check below*** where you prefer to be called:

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

Your Protected Health Information Designees:
If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information). This person (designee) will also be able to call the office on your behalf.
Please print the name and relationship to you/patient of each designee below:

Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:

_____ Check here if you ***do not want*** your health care information discussed with anyone other than yourself.

Confidential Voice Mail:
Please ***check below*** where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) blank if you ***do not wish*** to receive voice mails.

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

Information for Follow My Health Patient Portal:
Please ***write below*** an email address that we can send you a invite to participate in our new patient portal. The portal allows you the ability to communicate with Arbor Family in regards to: appointment requests, medication refill requests, and allows bidirectional communication between you and your provider and allows them to personally inform you regarding labs and other test results.

Email Address:

Your signature ***below*** confirms your approval of these updated HIPPA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE SIGNED**

SNORING/SLEEP APNEA QUESTIONNAIRE

IT IS ESTIMATED THAT UP TO 95% OF ADULTS WITH OBSTRUCTIVE SLEEP APNEA (OSA) REMAIN UNDIAGNOSED AND THAT 25% OF MEN AND 9 % OF WOMEN OVER 40 SUFFER FROM THE CONDITION. OSA IS A CHRONIC CONDITION WHICH PROFOUNDLY AFFECTS A SUFFERER'S QUALITY OF LIFE, COGNITIVE, CARDIOVASCULAR, AND METABOLIC HEALTH.

PLEASE FILL OUT THE FOLLOWING SCREENING QUESTIONNAIRE THAT WE MIGHT BETTER IDENTIFY YOUR RISK

PATIENT'S NAME: _____

TODAY'S DATE: _____

DO YOU OR HAVE YOU EVER BEEN TOLD YOU SNORE? YES NO

HAVE YOU EVER BEEN DIAGNOSED WITH SLEEP APNEA? YES NO

DO YOU WAKE UP FEELING TIRED AND REMAIN TIRED THROUGHOUT THE DAY? YES NO

DO YOU HAVE OR TAKE MEDICATIONS TO TREAT ANY OF THE FOLLOWING CONDITIONS:

HIGH BLOOD PRESSURE? YES NO

DIABETES? YES NO

ACID REFLUX? YES NO

NEW PATIENT INTERVIEW

ARE YOU HAPPY WITH YOUR SMILE? YES NO

ARE YOU INTERESTED IN A STRAIGHTER OR WHITER SMILE? YES NO

PLEASE PROVIDE US WITH ANY ADDITIONAL INFORMATION THAT MAY MAKE YOUR VISITS WITH US MORE ENJOYABLE _____

THE FOLLOWING CLINICAL EXAM TO BE COMPLETED BY DOCTOR OR HYGIENIST

BLOOD PRESSURE:

MAXILLARY / MANDIBULAR TORI? YES NO

MAXILLARY PALATAL RECESSION OR EROSION? YES NO

SCALLOPED BORDERS OF THE TONGUE? YES NO

HISTORY OF TMJ SYMPTOMS / CLENCHING AND GRINDING? YES NO

PATIENT RECOMMENDED TO SCHEDULE A SAME DAY CONSULTATION? YES NO

OralID®

Shine Light. Change Lives.

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID screening device into our office. The OralID examination will aid in visualization of oral mucosal abnormalities, such as cancer and pre-cancer. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of oral cancer is critical. If oral cancer is detected in its later stages, which typically only occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection
- Previous history of cancer

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID.

Our office charges $_____ per screening with the OralID. We will attempt to bill your insurance, but you will be responsible for any unpaid amount or denial by your insurance company.

☐ Yes, I request that your staff perform an examination with the OralID. I accept financial responsibility for this examination.

_____ _____ _____

Signature Name Date

☐ No, I prefer to not have this examination at this visit.

_____ _____ _____

Signature Name Date