Shea Family Dentistry
1930 Perkins Road
Baton Rouge, LA 70808
Phone: (225) 236-4994
www.drdanielshea.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.

Date: / /

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy):	Marital Status:	Social Security #:	Driver's Licence State & #:
		/ /		- -	

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Home Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone:	Occupation:
		- -	

Employer's Address:	City:	State:	ZIP Code:

Student Status:	School Name (if a full-time student):	Grade:	

Best places and times to contact you:	Send appointment reminders via:
	Text Message Email Mail

Please tell us where you heard about us (check all that apply):

Friend or Relative Newspaper Ad Radio Ad TV Ad Ad in Mail Saw our Office
Insurance Company Our Website Search Engine (Google, etc.)
Other Website: Other:

Was our website a factor in your decision to visit our practice? Yes No

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone:	Spouse/Parent Cell Phone:
		- -	- -

Other family members treated by us:	Additional Comments:

Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Emergency Contact Address:	City:	State:	ZIP Code:

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Person Responsible for Account (IF OTHER THAN PATIENT)

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #:	Driver's Licence State & #:	Holder of Dental Insurance for Patient:
/ /	- -		

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Billing Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone:	Occupation:
		- -	

Employer's Address:	City:	State:	ZIP Code:

Insurance Information

Primary Insurance

Insurance Holder's Name:	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insurance Company's Address:	City:	State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insurance Company's Address:	City:	State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am ultimately responsible for my bill, regardless of insurnace coverage. I authorize Shea Family Dentistry to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Shea Family Dentistry. I permit a copy of this authorization to be used in place of the original. I give Shea Family Dentistry, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):
	/ /

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Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Our Cancellation Policy

We want to thank you for selecting us as your dental care provider. We value all of our patients at our practice. At Shea Family Dentistry our philosophy is to provide the utmost dental care at a fair and honest price & time frame.

As you are aware, we are dedicated to the treatment of the whole patient, and getting you orally healthy. When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation.

When a patient fails to show up for an appointment, or cancels within 24 hours of the appointment, our valuable resources are idle. More importantly, a patient care opportunity is missed.

Shea Family Dentistry has a **$50** cancellation and/or No-Show Charge for any confirmed dental appointments cancelled or no showed within 24 hours of the scheduled visit.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict beyond his or her control. In this event, we ask that you call and personally speak to our scheduling coordinator in order to cancel your appointment at least 24 hours before your scheduled visit. This courtesy allows my office staff to schedule another patient who is also in need of dental care.

For your convenience, you may reschedule an appointment by calling our office at 225-344-0391, and speaking to one of our team members.

Again, we are committed to providing you with the best care possible, and to answer any questions you may have regarding your oral health and well-being.

We hope that you do understand that we are trying to provide ample enough time to give each patient the one on one treatment and time that you each deserve and want.

Signature (Type your name to sign electronically, or print and sign) Date (mm/dd/yyyy) / /

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Medical History

How is your general health? Good Fair Poor

Are you currently under medical treatment? If yes, what for?

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Do we have permission to contact your doctor regarding your care if necessary? Yes No

Physician's Name:	Phone: - -	Last Visit:

Address:	City:	State:	ZIP Code:

Have you ever had: Circle all that apply.

Arthritis
Cancer/Radiation / Chemotherapy
Difficulty breathing
Heart Disease
Heart murmur / trouble
Heart attack / stroke
Angina
Mitral valve prolapse
Irregular Heartbeat
Artificial Valves Artificial bones / joint
Head or face injury
Bleeding Disorders / Anemia
Fever blisters / cold sores
Anaphylaxis
Hepatitis A, B, or C
Hypertension (High BP)
Hypotension (Low BP)
Hearing disorders
Emotional problems
History of substance abuse / drug addiction
Thyroid disease
TMD / TMJ (jaw pain)
Kidney problems
Allergies / Sinus Trouble
Endocrine problems
HIV/AIDS
Diabetes/Hypoglycemia
Severe/frequent headaches
Intestinal disorders
Tonsillitis
Alzheimer's disease
Liver problems
Renal dialysis
Breathing Difficulties
Epilepsy/Seizures

Have you ever had an adverse reaction or allergies to any medication or substance? *Circle all that apply.*

Acrylic Novocaine Metals Xylocaine
Dental Anesthetics Valium Nitrous oxide Barbiturates
Latex Sedatives Iodine
Sulfa / Penicillin / Erythromycin / Tetracycline / Codeine / Aspirin

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Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). Yes No
Do you take or have you taken Phen-Fen or Redux? Yes No
Do you smoke or chew tobacco? Yes No
Do you use alcohol, cocaine, or other drugs? **(circle all that apply)**
Have you been treated in a hospital in the last five years? Yes No
If female, please mark if you are: Pregnant - If so, please enter your due date or week #: Trying to get pregnant Nursing On birth control
Please list all current prescriptions:
Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:
All of the above information is correct to the best of my knowledge. 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. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

For office use:
Reviewed by: Daniel R. Shea, DDS Date: / /

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Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Shea Family Dentistry to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
If signing on behalf of someone, explain your relationship to the patient:	

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.

The following circumstances prohibited the patient from signing the consent form:			
Describe your good faith effort to obtain the individual's signature on this form:			
Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date: / /

Dental Questionnaire

Patient Name_____

Are you currently having any dental problems? □ Yes □ No
If so, would you please express your concerns:

_____

_____

When was your last dental visit?
□ Less than 3 months ago □ 3-6 months ago □ 6 months-1 year ago
□ 1-2 years ago □ More than 2 years ago

Who provided your last dental treatment? _____
What was the reason for that visit? _____

When were your last dental x-rays?
□ Less than 3 months ago □ 3-6 months ago □ 6 months-1 year ago
□ 1-2 years ago □ More than 2 years ago

Have you ever received Orthodontic Treatment (braces)? □ Yes □ No
If so, how long was your treatment? _____

Did you wear retainers after Orthodontic Treatment? □ Yes □ No
If so, how long did you wear the retainers? _____

Have you had any of your Wisdom Teeth removed? □ Yes □ No
If so, please list the date _____

Do you find yourself clenching or grinding your teeth? □ Yes □ No

Do you often have headaches, or wake up with headaches? □ Yes □ No
If so, how often are they? _____

Have you ever been diagnosed with TMJ issues? □ Yes □ No

Have you ever whitened your teeth? □ Yes □ No
What product did you use? _____
Were you pleased with the results? _____

Does anyone in your family have Dentures or Partials? □ Yes □ No

Please check your main concerns:
□ Pain Avoidance □ Appearance □ Losing Teeth □ Gum/Periodontal Disease □ Cavities
□ Oral Cancer □ General Health □ Wasting/Exceeding Dental Insurance Limits
□ Routine Check Up □ Cleaning □ Bad Breath □ Smoking/Chewing Tobacco □ Other

_____

_____