Patient Information

Patient Name: _____ Date: _____

Last **First** **MI**

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

Social Security #: _____ Birthdate: _____ Driver's License # _____

Phone (Home): _____ (Work): _____ Ext: _____ Mobile _____

Email Address: _____ Employer: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Medical History:

Acid Reflux ☐	**Epstein-Barr** ☐	**Persistent Cough** ☐
Artificial Joint _____	**Fainting Spells** ☐	**Positive HIV or ARC** ☐
Allergic/ Take Acetaminophen ☐	**Glaucoma R L** ☐	**Pregnant: Y N Due** _____
Allergy to / Take Aspirin ☐	**Hearing Loss R L Aid** _____	**React to Local Anesthetic** ☐
Allergy to / Take Sedatives ☐	**Heart Attack/Pacemaker** ☐	**React to Nitrous** ☐
Anesthetic Reaction ☐	**Hepatitis A B C** ☐	**Recreational Drug Use** ☐
Anemia ☐	**Herpes/Cold Sores** ☐	**Scarlet Fever** ☐
Arthritis ☐	**High Blood Pressure** ☐	**Shunt Placed** _____
Asthma ☐	**Hives or Skin Rash** ☐	**Sjogren's Syndrome** ☐
Cancer _____	**Iodine** ☐	**Sleep Apnea- CPAP** ☐ **TAP** ☐ **Other Tx** ☐
Celiac Disease ☐	**Kidney Disease / Issues** ☐	**Snoring** ☐
Covid-19 Positive ☐	**Latex Allergy** ☐	**Stomach Ulcers** ☐
Diabetes ☐	**Lyme Disease** ☐	**Stroke** ☐
Dry Mouth ☐	**Multiple Sclerosis** ☐	**Tuberculosis** ☐
Epilepsy ☐	**Organ Replaced:** _____	**Veneral Disease** ☐
	Periodontal Disease	

Please List MEDICATION allergies: _____

_____

- Undergoing current or had previous radiation or chemotherapy treatment? ☐ Yes ☐ No
- Have you experienced serious difficulty with previous dental work? ☐ Yes ☐ No

  If yes, please explain: _____
- Experienced abnormal bleeding/discomfort following dental or medical procedures? ☐ Yes ☐ No

  If yes, please explain: _____
- I consider myself to be in ☐ Excellent ☐ Good ☐ Fair ☐ Poor Health?
- My last examination by my physician was _____

  Physician's Name and Phone #: _____

How did you learn about Microscope Dentistry/Dr. Shoup? ☐ Freedom 95 ☐ WIBC ☐ Other: _____

Insurance Subscriber Information

Subscriber's Name:_____
Last First MI

Subscriber's ID #: _____ Plan/Group #:_____ Subscribers DOB_____

Subscriber's Employer:_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Mailing Address for Claims: _____

Phone Number to contact member services: _____

Financial Agreement

We are honored you have selected **Microscope Dentistry by Shoup** as your dental healthcare provider. Thank you.

Prior to scheduling any appointment, your treatment options and fees will be fully reviewed with you. At all times, any financial arrangement is based on the total amount of your treatment regardless of any third party anticipated reimbursement. Any third party reimbursement is stated solely as an estimate only, not a guarantee of payment or coverage nor are services rendered on the assumption of our charges being reimbursed by any third party.

We are pleased to file your dental claims electronically including any narratives, photos or x-rays when furnished with your current dental plan information by completing the insurance information stated above. I grant my permission to have my dental insurance benefits paid directly to Microscope Dentistry by Shoup at any time I have an account balance.

I agree to make full payment at the time of service unless previous financial arrangements have been made. I acknowledge I may be charged a finance charge for any balance 30 days or older if it is not secured with a financial agreement. I acknowledge not attending a prescheduled appointment OR not giving a 3 business day notice of a desired appointment change, MDBS has the right to charge a broken appointment fee equal to ½ of the total amount of my prescheduled appointment and future appointments may require prepayment to be scheduled.

I agree to pay all collection fees, returned check fees, attorney fees and court costs including any applied finance charges incurred by Microscope Dentistry by Shoup in collection of any and all fees dues.

HIPAA (Health Insurance Portability and Accountability Act Consent: I give this practice my consent to use or disclose protected health information regarding myself and/or family members to carry out my/our treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I/we may review the practice's Notice of Privacy Practices for a more complete description of uses and disclosures) before signing this consent. I understand that this practice has the right to change their privacy practices and that I/we may obtain any revised notice at the practice.

I understand that I/we have the right to request a restriction of how my/our protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my/our requested restriction, they must follow the restriction(s). I also understand that I/we may revoke this consent at any time, by making the request in writing, except for information already used or disclosed.
Persons my information may be disclosed to:_____

I have read the above condition of treatment and payment as well as the HIPAA consent. I agree to their content by my signature below.

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

_____ **Date:** _____
Signature of patient, parent or guardian

Relationship to Patient: ☐ **Self** ☐ **Parent/Guardian** ☐ **Spouse** ☐ **Other**

NEW PATIENT COMPREHENSIVE EXAMINATION QUESTIONNAIRE

1. I am here today for: _____

2. I would like to know more about: **Dr. Shoup**____ **Less Invasive Dentistry**: _____

   Cavity Prevention____ **Biomimetic Dentistry**_____ **Microscope Dentistry**_____ **Other**_____

3. This makes my appointment more enjoyable:_____

4. The most important aspect of my dental health for me is: _____

5. Date of my last teeth/gum cleaning:_____ Teeth cleaning every _____ months

6. Do you use a manual or electric toothbrush? _____ Brand of electric: _____

7. Describe your brushing habits? _____ At home care routine? _____

10. Have you noticed bleeding, inflammation, tenderness, irritation, taste or bad/unpleasant breath?_____ Started: _____ Expected cause?_____

11. Do you avoid any part of your mouth while brushing? ___ _____Reason?_____

12. Have you been diagnosed with bone loss? _____When?____ Treatment_____

13. Have you been diagnosed with periodontal disease? When?_____ Treatment_____

13. Do you have missing teeth? _____Would you like to explore replacement? _____

14. When chewing, do you chew only on one side? _____Which side do you avoid?_____

    Reason _____

15. Does food catch between teeth? _____Where?_____Would you like to correct?_____

16. I am interested in improving the color, appearance, function of my teeth by:

    Whitening____Orthodontics_____ Cosmetic _____ Denture/Partial_____Other?_____

17. Do you experience aches or pain in the side of your face, neck, ears or head? _____

    Describe pain and treatment explored:_____

18. Are you subject to chronic headaches? _____Treatment?_____

19. Do you clench your teeth? Day_____Night_____Both_____Wear a night guard?_____

20. Other ways we can be of service to you:_____