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: Please circle past or present history of:

Acid Reflux	**Glaucoma R L**	**Persistent Cough**
Artificial Joint_____	**Hearing Loss R L Aid_____**	**Positive HIV or ARC**
Allergic to Acetaminophen	**Heart Disease**	**Pregnant: Y N Due _____**
Allergy to Take Aspirin	**Heart Attack/Pacemaker**	**React to Local Anesthetic**
Allergy to Take Sedatives	**Hepatitis A B C**	**React to Nitrous**
Anesthetic Reaction	**Herpes/Cold Sores**	**Recreational Drug Use**
Anemia	**High Blood Pressure**	**Scarlet Fever**
Arthritis	**Hives or Skin Rash**	**Shunt Placed_____**
Asthma	**Iodine**	**Sjogren's Syndrome**
Cancer_____	**Kidney Disease / Issues**	**Sleep Apnea- CPAP TAP Other Tx**
Celiac Disease	**Latex Allergy**	**Snoring**
Covid-19 Positive	**Lyme Disease**	**Stomach Ulcers**
Diabetes Type I II Insulin	**Multiple Sclerosis**	**Stroke**
Dry Mouth	**Organ Replaced: _____**	**Thyroid Hyper/Hypo/Cancer**
Epilepsy	**Periodontal Disease**	**Tuberculosis**
Epstein-Barr		**Venereal 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 Dr. Shoup? Freedom 95 WIBC I HEART PODCAST FM 105 Other:_____

Insurance Subscriber Information

Subscriber's Name:_____
Last **First** **MI**

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

Subscriber's Employer:_____

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

Ins Name/Mailing Address:_____

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. I use a manual or electric toothbrush? _____ Brand of electric: _____
7. Describe your teeth homecare routine: _____ _____
8. Do you experience bleeding, inflammation, tenderness, irritation, taste or bad/unpleasant breath?_____ Started: _____ Expected cause?_____
9. Do you avoid any part of your mouth while brushing? ___ _____Reason?_____
10. Have you been diagnosed with bone loss? _____When? _____ Treatment_____
11. 12. Do you have missing teeth? _____Would you like to replace them? _____
12 .Do you chew only on one side? _____Which side do you avoid?_____
    Reason _____
13. Does food catch between teeth? _____Where?_____Would you like to correct?_____
14 I am interested in improving the color, appearance, function of my teeth by: Whitening___ Orthodontics_____ Cosmetic _____ Implant/Denture/Partial____Other?_____
15. Describe any pain/popping/clicking experienced on the side of your face, neck, ears or head?
    _____
16. Do you experience chronic headaches? _____Treatment?_____
17. Do you clench/grind your teeth? Day_____Night____Both___Wear a night guard?_____
18. Sleep: Do you fall asleep easily?_____ How often do you get up in the night?_____
19. Do you dream nightly? _____ Snore? _____ Mouth or Nose Breather_____

Microscope DENTISTRY

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I,_____, Date of Birth_____, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results, date of services.

- Sensitive Protected Health Information (HIV- related information)
- You may disclose information to my family members and/or non-family members

Please list the name, phone number and relationship

NAME PHONE NUMBER RELATIONSHIP

_____

_____

_____

Protected Health Information may be left for me on my answering machine/voicemail:

Phone Number_____

- You may leave me a text message: Text Phone Number_____
- You may email me (unencrypted) for dental appointments:

  Email Address:_____
- You may fax me for dental information: Fax Number_____
- Other_____

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____
Signature:_____
(Patient's Signature (or Guardian, if minor)
Date:_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement

Other (Please specify)

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Noblesville, IN 46060

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Fax: 317-776-1129
Email: office@drshoup.com