WELCOME TO OUR PRACTICE

Keri A. Shenker, D.M.D., P.A.

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____
(First) (Last) (Prefer to be called)

Address _____ Email: _____

City _____ State _____ Zip _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widower ☐ Separated

Home Phone _____ Cell/Pager _____ Business Phone _____

Employer _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

DENTAL INSURANCE / PAYMENT

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Secondary Insurance: ☐ Y ☐ N _____

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How often Do You Brush? _____

Please check all that apply:

Bad Breath/Tastes ..... ☐
Bleeding Gums ..... ☐
Blisters on Lips or Mouth ..... ☐
Finger Nail Biting ..... ☐
Grinding Teeth ..... ☐
Smoke / Chew tobacco ..... ☐
Snoring ..... ☐

Loose Teeth or Broken Fillings ..... ☐
Orthodontic Treatment ..... ☐
Oral Surgery ..... ☐
Periodontal Treatment ..... ☐
Sensitivity to Cold ..... ☐
Sensitivity to Heat ..... ☐
Cosmetic Concern ..... ☐

Sensitivity to Sweets ..... ☐
Sensitivity When Biting ..... ☐
Frequent Headaches ..... ☐
Jaw, Head or Neck Injuries ..... ☐
Jaw Difficulty: Clicking and/or Pain . ☐
Nervous about Dental Treatment ... ☐

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Have you been under treatment within 2 yrs.	☐	☐
2. Are you currently taking any medication?	☐	☐
3. Have you taken medication during the past 2 yrs.	☐	☐
4 Do you wear contact lenses?	☐	☐
5. Have you had any allergic reactions to the following:		
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Latex	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐
6. (Women Only) Are You:		
Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

AIDS ☐	Cough – persistent or bloody ☐	Neurological Disorders ☐
Anemia ☐	Diabetes ☐	Pacemaker ☐
Arthritis, Rheumatism ☐	Emphysema ☐	Psychiatric Care ☐
Artificial Heart Valves ☐	Epilepsy ☐	Radiation Treatment ☐
Artificial Joints ☐	Fainting or Dizziness ☐	Rheumatic Fever ☐
Asthma ☐	Glaucoma ☐	Scarlet Fever ☐
Back Problems ☐	Headaches ☐	Shortness of Breath ☐
Bleeding abnormally, with extractions or surgery ☐	Heart Murmur ☐	Sinus Trouble ☐
	Heart Attack; Disease ☐	Skin Rash ☐
Blood disease/Transfusions ☐	Hepatitis-Type _____ ☐	Stroke ☐
Cancer ☐	Hemophilia ☐	Swelling of Feet/Ankles ☐
Chest Pain ☐	High Blood Pressure ☐	Thyroid Problems ☐
Chemotherapy ☐	HIV Positive ☐	Tuberculosis ☐
Chronic Fatigue Syndrome ☐	Kidney Disease ☐	Tumors or Growth on Head/Neck ☐
Circulatory Problems ☐	Latex Sensitivity ☐	Ulcer ☐
Congenital heart Disease ☐	Liver Disease ☐	Veneral Disease ☐
Cortisone Treatments ☐	Mitral Valve Prolapse ☐	

List Medications: _____

ASSIGNMENT AND RELEASE

I understand responsibility for payment of dental services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts by signing this agreement. I agree to be responsible for payment of services not paid in whole or in part by my dental care payor.

I hereby authorize payment of insurance benefits directly to Dr. Shenker.

I understand the information on both sides of this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Dr. Shenker of any changes in my health history or medications.

Responsible Party Signature: _____ Date: _____

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FINANCIAL POLICY

Thank you for choosing us as your dental care provider. In being committed to customer service, we feel that it is very important that you understand your financial obligation.

WITH A DENTAL BENEFITS PLAN

YOUR RESPONSIBILITY:

Your dental benefits plan is an agreement between you and your insurance company. Each plan is specific to the employer. In addition, we treat based on what is best for the patient which is not always consistent with what your insurance benefit plan will cover. ***This office is not responsible for verifying detailed benefit coverage, limitations or maximums.*** (Pre-determinations can be submitted at your request. Please be aware that this will delay treatment).

When we refer a patient to another dental office for treatment, we are not made aware of any fees that will be applied to your insurance maximum nor is the other office aware of benefits used at our office. It is, therefore, ***your responsibility*** to contact your insurance company to determine the amount of benefits you have remaining. This will affect your financial responsibility at any dental office.

As a courtesy to you we will:

- verify your eligibility with your dental benefits carrier;
- obtain a basic overview of benefits; and
- file your insurance after treatment is completed

FOR ALL PATIENTS

We accept Cash, Check, Visa, Master Card, Discover and American Express. We also offer extended payment options through Care Credit Financing.

Payment, including deductibles, co-payment estimates and non-covered services, is due at the time of service. As insurance co-payments are an estimate, balances remaining after insurance payment has been made is your responsibility.

There will be a 15% annual finance fee if your balance remains outstanding for more than 90 days. In addition, if your account balance exceeds 120 days without a written financial arrangement, it will be turned over to a collection agency and you will then be responsible for a $25.00 transaction fee in addition to all collection and attorney's fees incurred in the legal proceedings associated with collections.

CANCELLATION POLICY

If you are unable to keep a scheduled appointment, please give at least 48 hours notice to ensure you will not be charged for the missed appointment.

I have read and agree to this Financial and Cancellation Policy.

_____ _____

Signature of Responsible Party *Date*

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 Oral ID screening device into our office. The Oral ID examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless, and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the Oral ID dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically 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**

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 Oral ID to reduce the mortality of late stage detection.

Dental insurance might not cover the Oral ID exam. However, our office is happy to verify your coverage for you. **The fee for this enhanced examination is $25.**

YES. I authorize the clinician to perform the Oral ID exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name:_____

Signature:_____ Date:_____

NO. I would prefer not to have the Oral ID exam at this time.

Print name:_____

Signature:_____ Date:_____