Name: _____ Today's Date: _____

Patient Information (CONFIDENTIAL)

Name: _____ SS#/SIN: _____ Birthdate: _____
Last Name, First Name, Middle Initial

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status (check appropriate box): ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If Student, Name of School/College: _____ ☐Full Time ☐Part Time

Address: _____ City: _____ State: _____ Zip: _____

Patient or Parent/Guardian's Employer: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent/Guardian's Name: _____

Employer: _____ Work Phone: _____

Whom May We Thank for Referring You: _____

Person to Contact in Case of Emergency: _____ Phone Number: _____

Primary Insurer, If Not Patient

Subscriber: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Birthdate: _____

Email Address: _____ SS#/SIN: _____

Employer: _____ Work Phone: _____

Secondary Insurer, If Not Patient

Subscriber: _____ Relationship to Patient: _____

Birthdate: _____ SS#/SIN: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy/ID #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Today's Date: _____

Patient Medical History

Physician's Name: _____ Date of Last Exam: _____

Office Address: _____ Office Phone: _____

Yes No

☐ ☐ Are you under medical treatment now?

☐ ☐ Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?
If yes, please explain: _____

_____

☐ ☐ Are you taking any medication(s) including non-prescription medicine?
If yes, what medication(s) are you taking?:

_____

☐ ☐ Have you ever taken Fen-Phen/Redux?

☐ ☐ Do you use tobacco?

☐ ☐ Do you use controlled substances?

☐ ☐ Are you wearing contact lenses?

Are you allergic to or have you had any reactions to the following?

Yes No

☐ ☐ Local Anesthetics (e.g. Novocain)

☐ ☐ Aspirin

☐ ☐ Barbiturates

☐ ☐ Iodine

☐ ☐ Latex Rubber

☐ ☐ Any Metals (e.g. nickel, mercury, etc.)

☐ ☐ Penicillin or Other Antibiotics_____

☐ ☐ Sedatives

☐ ☐ Sulfa Drugs

☐ ☐ Other (please list): _____

☐ ☐ Do you have a persistent cough for throat clearing not associated with a known illness (lasting more than 3 weeks)?

For women only:

☐ ☐ Are you pregnant or think you may be pregnant?

☐ ☐ Are you nursing?

☐ ☐ Are you taking oral contraceptives?

Please check if you have or have had any of the following:

Yes No

☐ ☐ AIDS or HIV Infection

☐ ☐ Alzheimer's/Dementia

☐ ☐ Anemia

☐ ☐ Angina

☐ ☐ Arthritis

☐ ☐ Asthma

☐ ☐ Cancer _____

☐ ☐ Cardiac Pacemaker

☐ ☐ Chest Pains

☐ ☐ Diabetes

Yes No

☐ ☐ Easily Winded

☐ ☐ Emphysema

☐ ☐ Epilepsy/Convulsions

☐ ☐ Fainting/Seizures

☐ ☐ Frequently Tired

☐ ☐ Glaucoma

☐ ☐ Hay Fever/Allergies

☐ ☐ Heart Attack, When_____

☐ ☐ Heart Disease

☐ ☐ Heart Murmur

Yes No

☐ ☐ Heart Trouble

☐ ☐ Hepatitis/Jaundice ___

☐ ☐ High Blood Pressure

☐ ☐ Kidney Disease

☐ ☐ Leukemia

☐ ☐ Liver Disease

☐ ☐ Low Blood Pressure

☐ ☐ Mitral Valve Prolapse

☐ ☐ Parkinson's

☐ ☐ Radiation Therapy

Yes No

☐ ☐ Recent Weight Loss

☐ ☐ Joint Replacement or Implant

☐ ☐ Respiratory Problems

☐ ☐ Rheumatic Fever

☐ ☐ Sexually Transmitted Disease

☐ ☐ Stroke

☐ ☐ Swollen Ankles

☐ ☐ Stomach Troubles/Ulcers

☐ ☐ Thyroid Problems

☐ ☐ Tuberculosis

☐ ☐ Other_____

General Dentist Information

Name and location of general dentist _____ Date of Last Exam: _____

Yes No

☐ ☐ Do you have any sores or lumps in or near your mouth?

☐ ☐ Have you had any head, neck, or jaw injuries?

☐ ☐ Do you clench or grind your teeth?

☐ ☐ Have you ever had any prolonged bleeding following extractions

Have you ever had any of the following with your jaw?

Yes No

☐ ☐ Clicking

☐ ☐ Pain (joint, ear, side of face)

☐ ☐ Difficulty in opening or closing

☐ ☐ Difficulty in chewing

Name: _____ Today's Date: _____

Tooth Information

What is the concern? _____

How long have you had the problem? _____

Does the tooth keep you up at night?	☐Yes	☐No	What causes the pain?	☐Chewing	☐Hot	☐Cold
Have you had any traumatic injury to the area?	☐Yes	☐No	Is the tooth:	☐Loose?	☐Broken?	☐Cracked?
Do you have swelling?	☐Yes	☐No	Have you had swelling before?		☐Yes	☐No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Shugars to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Today's Date _____

Signature of patient (or parent/guardian, if minor)

Treatment Consent

Please review the following consent; you are required to sign it prior to initiation of treatment. This, however, does not commit you to treatment. This is my consent to the endodontic procedures indicated and any other procedures necessary or advisable to aid in the chance of success of the planned endodontic therapy performed by Dr. Shugars with my consent. I agree to the use of local anesthesia if Dr. Shugars finds it necessary to aid in pain control during the procedure. Possible complications of root canal therapy, anesthesia, or surgical root canal therapy may include swelling, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum, or tongue, which rarely occurs and even more rarely is permanent.
I understand root canal treatment is a procedure to retain a tooth that may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure and such cannot be guaranteed. Due to the local conditions of the tooth and surrounding tissues, and sometimes due to the patient's general health, it may be impossible to successfully treat your tooth. On rare occasions, a tooth which has had root canal therapy may require retreatment, surgical correction or even extraction. During treatment, there is a possibility of instrument separation with the root canals, perforations (extra opening made in the tooth), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure while locating canals, and fractured teeth. **I also understand that only the root canal treatment will be performed in this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be done by my regular dentist.** The other treatment choices, besides root canal therapy, include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include but are not limited to pain, infection, swelling, loss of tooth, and infection in other areas. If I am under the care of Dr. Shugars, I understand it is my responsibility to report any problems pertaining to the tooth (teeth) under treatment or medication prescribed. I acknowledge that no guarantee or assurances have been given by anyone as to the results that may be obtained.

I, _____, agree to the above stated policy.

_____ _____

Signature Date

Name: _____ Today's Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, was offered/received a copy of this office's Notice of Privacy Practices.

_____ _____ _____

Signature Date (other authorized members)

Office Policy

Our office policies regarding submitting and receiving insurance payments are as follows:

1. It is your responsibility to contact your dental insurance company to determine your level of benefits. The amount the insurance company states they will pay is only an estimate. If your insurance pays less than expected, you will receive a statement from our office and the balance is due within 30 days.
2. If your dental insurance company pays more than expected, you will receive a refund check from our office.
3. If the dental insurance company does not make payment within 90 days of claim submittal, you are responsible for the balance owing and it is YOUR responsibility to follow-up with your insurance company regarding any problems or delays you may have with your claim.
4. I also understand that Dr. Shugars **does not participate** with Medicare and **will not bill Medicare** for any services or expenses rendered for treatment on my behalf. I agree that I am responsible for payment of all services rendered on my or my dependent's behalf.

Payment Options

We gladly accept cash, check, MasterCard, VISA and Discover. Please indicate your preferred method of payment for us to use today to process any balance owing on your account.

☐Cash ☐Check ☐Mastercard ☐VISA ☐ Discover ☐ Care Credit

Patient Appointment Agreement

At Dr. Eric T. Shugars, DDS, MS, PLC, we strive to provide great dental care to all of our patients. To help us achieve this goal we have adopted the *Patient Appointment Agreement.* When you schedule an appointment(s) with us we are setting aside time specifically for you and your care. When this appointment is missed or canceled late, it becomes time that we cannot be used to treat another patient.

Our policy is as follows: We require that you give our office a minimum of **24 hours'** notice in the event that you need to reschedule your appointment. This allows other patients to be scheduled in that appointment spot. If an appointment is missed without contacting our office within the required time, this is considered a missed appointment. A fee of **$50.00** per appointment will be automatically charged to your account; this fee cannot be billed to your insurance and will be your direct responsibility. Exceptions will be made on an individual basis in cases such as weather, illness, or family emergency.

Further, in order to keep our staff, doctor, and other patients' on time, a patient that is **10 minutes** or more late to their scheduled appointment may be considered a missed appointment and the **$50.00** fee may be charged. Our staff attempts to contact each patient to remind them of their appointment. However, this is not a guarantee, and ultimately is your responsibility to make your scheduled appointments.

If you have any questions regarding this policy please let our staff know.

I understand the Patient Appointment Agreement of this practice and I agree to be bound by these terms. I also understand and agree that such terms may be amended by this practice at any time.

I, _____, agree to the above stated policy.

_____ _____

Signature Date