SHEA DENTAL

Alan Siegel DDS, Joshua Raiffe DMD, PLLC

Today's Date: _____

PATIENT REGISTRATION

We are pleased to welcome you to our practice. To assist us in serving you, please take a few minutes to fill out this form as completely as you can. The doctors and staff will be happy to assist in answering any questions or concerns you may have. We look forward to working with you and maintaining your dental health.

PATIENT INFORMATION

First Name:	Last Name:	Middle Name:
Preferred Name:	Marital Status:	
Date of Birth: / Age:	SSN:	Driver's License:
Mailing Address:		
City, State, Zip:		
Home Phone:	Cell Phone:	Email:
I authorize Shea Dental to contact me for matters regarding my clinical care via ☐ Text Message ☐ Email		
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired	Student Status: ☐ Full Time ☐ Part Time	
Preferred Hygienist:	Preferred Dentist:	
Emergency Contact Name:	Phone:	Relationship:

REFFERAL

Whom may we thank for referring you to our practice? ☐ Facebook ☐ Google ☐ Insurance

☐ Another Patient – Name: _____ ☐ Other: _____

RESPONSIBLE PARTY'S INFORMATION (If someone other than the patient is responsible for account)

First Name:	Last Name:	Middle Name:
Mailing Address:		
City, State, Zip:		
Home Phone:	Cell Phone:	Email:
Birth Date:	SSN:	Driver's License:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

PRIMARY INSURANCE INFORMATION

Subscriber Name:			Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Subscriber SSN:	Subscriber DOB:		Insurance Company:		
Subscriber Employer Name:			Phone:		
Mailing Address:			Address:		
City:	State	Zip	City:	State:	Zip
Group #	Carrier/Member ID:		Rem. Benefits:	Rem. Deduct:	

SECONDARY INSURANCE INFORMATION

Is Patient Covered by Additional Insurance? ☐ Yes ☐ No

Subscriber Name:			Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Subscriber SSN:	Subscriber DOB:		Insurance Company:		
Subscriber Employer Name:			Phone:		
Mailing Address:					
City:	State	Zip	City:	State:	Zip
Group #	Carrier/Member ID:		Rem. Benefits:	Rem. Deduct:	

SHEA DENTAL

MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	If yes, please explain: _____
Have you had a serious illness, operation, or been hospitalized in the past 10 years?	☐ Yes	☐ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel, or any or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes, please explain: _____
Are you on a special diet?	☐ Yes	☐ No	If yes, please explain: _____
Do you use tobacco?	☐ Yes	☐ No	If yes, please explain: _____
Do you use controlled substances?	☐ Yes	☐ No	If yes, please explain: _____
Do you have a CPAP?	☐ Yes	☐ No	

Are you…

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐ N/A

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ Yes ☐ No If yes, please explain _____

Do you have, or have had any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Radiation Treatments	☐	☐	Alzheimer's/Dementia	☐	☐
Diabetes	☐	☐	Hepatitis A	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐
Herpes	☐	☐	High Blood Pressure	☐	☐	Epilepsy or Seizures	☐	☐	Artificial Heart Valve	☐	☐
Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Artificial Joint	☐	☐	Excessive Thirst	☐	☐
Hypoglycemia	☐	☐	Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Sinus Trouble	☐	☐
Breathing Problems	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐	Low Blood Pressure	☐	☐
Cancer	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐	Chemotherapy	☐	☐
Tonsillitis	☐	☐	Heart Attack/Failure	☐	☐	Osteoporosis	☐	☐	Cold Sores/Fever Blisters	☐	☐
Tumors or Growth	☐	☐	Congenital Heart Disorder	☐	☐	Heart Pacemaker	☐	☐			
Ulcers	☐	☐	Heart Trouble/Disease	☐	☐	Psychiatric Care	☐	☐	Parathyroid Disease	☐	☐
Acid Reflux/GERD	☐	☐	Kidney Disease	☐	☐				Venereal Disease	☐	☐

Have you ever had any serious illness not listed above? ☐ ☐ If yes, please explain: _____

Dentist Comments:

To the best of my knowledge, the questions on this form have been accurately answered. 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.

Signature of Patient, Parent or Guardian: _____

✗

Date:

11111 N Scottsdale Rd Ste 120 | Scottsdale, AZ 85254 | P 480.998.3923 | F 480.922.0864 | frontoffice@sheadentalaz.com

SHEA DENTAL

DENTAL HISTORY

Patient's Name: _____ Date of Birth: _____

What is the reason for your visit?	Are you in pain/discomfort? If so, where?
When was your last dental visit?	What was done then?
How often did you visit the Dentist before then?	When was your last dental cleaning?
Previous Dentist (Name and Location)	
Have you had a complete series of dental films (X-Rays) taken - When & Where?	
How often do you brush your teeth? ☐ Electric ☐ Manual	How often do you floss your teeth? Floss of choice?

For the following questions, please mark (X)

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?	☐	☐	Do you clench or grind your teeth?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	Do you bite your lips or cheeks frequently?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	Have you noticed any loosening of your teeth?	☐	☐
Is your mouth dry?	☐	☐	Does food tend to become caught between your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐	Have you ever had periodontal treatment (gums)?	☐	☐
Have you had any head, neck, or jaw injuries?	☐	☐	Have you ever had orthodontic treatment (braces)?	☐	☐
Have you experienced any of the following problems? :			Have you ever worn a dental appliance?	☐	☐
Clicking in your jaw	☐	☐	If so, what kind? ☐ Retainer ☐ Night Guard ☐ Other?		
Pain (joint, ear, side of face)	☐	☐	Do you wear dentures or partials?	☐	☐
Difficulty in opening or closing your jaw	☐	☐	If yes, give the date they were placed:		
Difficulty in chewing	☐	☐	Have you ever had a difficult time getting or staying numb?	☐	☐
Do you have frequent headaches?	☐	☐	Have you had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions or a dental procedure?				☐	☐
If so, please explain:					

If you could change ANYTHING about your smile, what would you change? ☐ Nothing, I love my smile!

☐ Whiter ☐ Straighter ☐ Close Space ☐ Repair Chipped Teeth ☐ Replace missing teeth ☐ less gums showing

☐ Replace old crowns or caps that do not match ☐ Replace Black Mercury fillings with tooth-colored restorations

Other: _____

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 THE DENTIST TO RELEASE NAY INFORMATION INCLUDING THE DIAFNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO MY CHILD OR ME DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYOR AND/OR HEALTH PRACTIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL CROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICE. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON BEHALF OF MY DEPENDENTS.

Date:

✗ _____

Signature of Patient, Parent or Guardian

Date:

_____

Doctor's Signature

Doctor's Comments: _____

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SHEA DENTAL

Today's Date: _____

GUM DISEASE RISK ASSESSMENT

Patient's Name: _____ Date of Birth: _____

In our practice, we strive to provide our patients with optimal oral health. We are focused on preventing or limiting periodontal (gum) disease, and dedicated to identifying and treating disease early, when the pain and costs associated with treatment are much less.

According to the National Center for Biotechnology Information, *"Significant associations between periodontal disease and cardiovascular disease, diabetes mellitus, preterm low birth weight, and osteoporosis have been discovered, bridging the once –wide gap between medicine and dentistry."*

Please take a few minutes to answer the questions below so that we can assess your individual risk for gum disease and tailor our treatment recommendations to your specific needs.

Risk Factors For Gum Disease	Yes	No	Score	Facts
Do you floss daily?	☐ Y = 0	☐ N = 2		Per American Dental Association (ADA): 20% never floss; 40% 1 x per day
Are you age 35 or older?	☐ Y = 2	☐ N = 0		
Do you have a family history of premature adult tooth loss and/or gum disease?	☐ Y = 2	☐ N = 0		Per Centers for Disease Control (CDC): 47% age 30+ have periodontal disease; 70% of Americans age 65+ have periodontal disease
Do you have a family history of heart disease and/or are you taking medication for hypertension?	☐ Y = 2	☐ N = 0		Per CDC: 34% of adults age 40+ have tooth loss
Are you taking medication for diabetes?	☐ Y = 2	☐ N = 0		Per CDC: Hypertension: 29% of population; Heart Disease: 11% overall, 48% women; 46% Men
Have you ever been a tobacco user (including smokeless tobacco) and/or smoker of any kind (including marijuana/vape)?	☐ Y = 2	☐ N = 0		Per CDC: 30 % of Americans have diabetes or pre-diabetes; age 45-64: 17% have diabetes; age 65+: 25%
Is there redness on toothbrush or in the sink when you rinse after brushing?	☐ Y = 1	☐ N = 0		Per CDC: Tobacco use and smoking of any kind doubles the risk of periodontal disease
Do you have persistent bad breath (noticed by you, your partner/friend/colleague)?	☐ Y = 1	☐ N = 0		
Have you noticed a movement/shifting of teeth (gaps developing, tooth/teeth mobility)?	☐ Y = 1	☐ N = 0		
Do you occasionally experience discomfort/pain when eating/chewing?	☐ Y = 1	☐ N = 0		

Total Score: _____

LOW TO MODERATE RISK: **Total Score of 0 – 3**

MODERATE TO HIGH RISK: **Total Score of 4 – 9**

HIGH RISK: **Total Score of 10 or higher**

SHEA DENTAL

FINANCIAL POLICY AND AGREEMENT

Patient's Name: _____ Date of Birth: _____

INSURANCE ASSIGNMENTS

Regardless of the patient's insurance plan, the patient is responsible for the full amount of the charges for the treatment rendered. When the patient's insurance plan is one in which this office participates, the patient is expected to pay the patient's estimated portion at the time of treatment. This office can make no guarantee of the insurance payment as estimated. Claims are submitted promptly after treatment is rendered, and in most cases the insurance company pays promptly. If payment is delayed for more than 60 days, the patient will be billed for the full charges.

Often the insurance company pays on least costly treatment. This office charges for treatment rendered, and the patient is responsible for the difference between the UCR charge or PPO fee (whichever is applicable) for treatment performed, and the UCR charge or PPO fee for the treatment the insurance company will pay for. Tooth colored fillings may be paid at silver benefits. Tooth colored crowns may be paid at full metal or base metal benefits.

Our administrative staff prides itself on helping our patients maximize their benefits. We are always available to answer your questions.

COLLECTION FEES

Fees incurred to enforce payment required by this agreement will be paid by the delinquent patient (or guardian) whose failure to pay required said costs to be incurred.

FINANCIAL CONSENT

Submission to treatment implies consent as outlined in this service agreement. The patient (guardian) agrees to be fully responsible for payment in full for procedures performed in this office, including treatment, which is not a benefit of any dental insurance the patient may have.

I certify that I have read and understood and agree to the Financial Policy. A copy of the Financial Policy Agreement was given to me when requested.

✗ _____ Date: _____

Signature of Patient, Parent or Guardian

_____ Date: _____

Doctor's Representative

SHEA DENTAL

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY AND/OR FRIENDS

Patient's Name: _____ Date of Birth: _____

Shea Dental is authorized to discuss my dental care and may release my confidential health information to the following:

_____ _____

Name Relationship

_____ _____

Name Relationship

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Shea Dental, 11111 N Scottsdale Rd Ste 120, Scottsdale, AZ 85254. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effective until revoked by the patient or representative signing the authorization.

✗ _____ Date: _____

Signature of Patient, Parent or Guardian

OFFICE POLICY

EMERGENCIES

If you have an emergency during office hours, we make every effort to make an immediate appointment. If you have an emergency when the office is closed, our phone message will give you instructions. You will be told to dial Dr. Siegel's number (480) 882-1864 and the doctor will call you back as soon as possible. Emergency calls made between 11:00PM and 8:00AM will be returned in the morning.

If immediate attention is required during those hours, please call your local hospital emergency room.

CANCELLATIONS

There is a $50-$75 per hour charge for missed appointments, and for appointments canceled without 24-hour notice. This fee will be billed to you and will not be paid by your insurance company. Please avoid confusion by informing us of any appointment changes at least one day in advance.

The doctors and staff are happy to answer any questions you wish to ask. We welcome the opportunity to serve your dental needs.

✗ _____ Date: _____

Signature of Patient, Parent or Guardian

SHEA DENTAL

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient's Name: _____ Date of Birth: _____

I have received and understand this practice's notice of privacy practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information. This includes, but is not limited to,

1. A statement that this practice is required by law to maintain the privacy of protected health information.
2. A statement that this practice is required to abide by the terms of the notice currently in effect
3. Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and healthcare operations
4. A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
5. A description of uses and disclosures that are prohibited or materially limited by law
6. A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
7. A description of uses and disclosures that are prohibited or materially limited by law.
8. A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
9. My individual rights with respect to protected health information and a brief description of how I may exercise there rights in relation to
    - The rights to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Date: _____

_____
Signature of Patient, Parent or Guardian

Date: _____

_____
Doctor's Representative