SHEA DENTAL
Alan Siegel, DDS, PC | Roya Asin, DMD

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 Initial:
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	Preferred Name:		Marital Status: ☐ Single ☐ Married
Date of Birth:	Age:	SSN:	Driver's License:
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Ext:	Cell Phone:
Email		Preferred Method of Contact: ☐ Text ☐ Call Cell ☐ Call Home	Preferred Method of Appointment Reminders: ☐ Text ☐ Email
Preferred Dentist:	Preferred Hygienist:		
Employment Status: ☐ Full Time	☐ Part Time	☐ Retired	☐ Student
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)

First Name:	Last Name:		Middle Initial:
Address:			
Apartment #	City:	State:	Zip:
Home Phone:	Work Phone:	Ext:	Cell Phone:
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	
Insured SSN:	Insured DOB:	Insurance Company:	
Insured Employer:		Phone:	
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	
Insured SSN:	Insured DOB:	Insurance Company:	
Insured Employer:		Phone:	
Address		Address:	
City: State Zip		City:	State: Zip
Group #	Carrier/Member ID:	Rem. Benefits:	Rem Deduct:

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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:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes, please explain:
Are you taking any medications, pills or drugs?	☐ Yes	☐ No	If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	
Have you ever taken Fosamax, Boniva, Actonel or any or any other medications containing bisphosphonates?	☐ Yes	☐ No	
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	If yes, please explain:

Women: Are you…

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

Are you allergic to any of the following? ☐ Yes ☐ No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Radiation Treatments	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Scarlet Fever	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Shingles	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Sickles Cell Disease	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Spina Bifida	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Breathing Problems	☐	☐
Blood Transfusion	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Bruise Easily	☐	☐
Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐	Glaucoma	☐	☐
Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐	Cancer	☐	☐	Hay Fever	☐	☐
Lung Disease	☐	☐	Thyroid Disease	☐	☐	Chemotherapy	☐	☐	Heart Attack/Failure	☐	☐
Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐	Chest Pain	☐	☐	Murmur	☐	☐
Osteoporosis	☐	☐	Tuberculosis	☐	☐	Cold Sores/Fever Blisters	☐	☐	Heart Pacemaker	☐	☐
Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐	Congenital Heart Disorder	☐	☐	Heart Trouble/Disease	☐	☐
Parathyroid Disease	☐	☐	Ulcers	☐	☐	Convulsions	☐	☐			
Psychiatric Care	☐	☐	Venereal Disease	☐	☐	Yellow Jaundice	☐	☐			

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain:

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.

✗ _____ Date: _____

Signature of Patient, Parent or Guardian

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DENTAL HISTORY

Patient's Name: _____ Date of Birth: _____

What is the reason for your visit?	
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?	How often do you floss your teeth?

For the following questions, please mark (X) your responses to the following questions.

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing	☐	☐	Do you clench or grind your teeth	☐	☐
Is your drinking water fluoridated	☐	☐	Do you bite your lips or cheeks frequently	☐	☐
Are your teeth sensitive to hot or cold liquids/foods	☐	☐	Have you noticed any teeth becoming loose?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods	☐	☐	Does food tend to become caught between your teeth	☐	☐
Is your mouth dry	☐	☐	Have you ever had periodontal treatment (gums)	☐	☐
Do any of your teeth feel painful	☐	☐	Have you ever had orthodontic treatment (braces)	☐	☐
Do you have any sores or lumps in or near your mouth	☐	☐	Have you ever worn a bite plate or other appliance	☐	☐
Have you had any head, neck or jaw injuries	☐	☐	Have you had any difficult extractions in the past	☐	☐
Have you experienced any of the following problems:			Have you ever had any prolonged bleeding following:		
Clicking in your jaw	☐	☐	Extractions	☐	☐
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 received oral hygiene instructions regarding the care of your teeth and gums	☐	☐
Do you have frequent headaches	☐	☐			

If you could change ANYTHING about your smile, what would you change?

☐ 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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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 rise 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**

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AUTHORIZATION FOR RELEASE OF INFORMATION

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., Suite 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 redisclosure 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 either Dr. Siegel's number (480) 882-1864 or Dr. Asin's number (602) 370-6845, 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 $25-$50 charge for missed appointments, and for appointments cancelled 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

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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