Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # ____________
SS#/SIN ____________
Date ____________

Patient Information (CONFIDENTIAL)

Name ____________ Birthdate ____________ Home Phone ____________
Address ____________ City ____________ State/Prov. ________ Zip/P.C. ________
Email ____________ Cell Phone ____________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College ____________ City ____________ State/Prov. ________ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer ____________ Work Phone ____________
Address ____________ City ____________ State/Prov. ________ Zip/P.C. ________
Spouse or Parent/Guardian's Name ____________ Employer ____________ Work Phone ____________
Whom may we thank for referring you? ____________
Person to contact in case of emergency ____________ Phone ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship to Patient ____________
Address ____________ Home Phone ____________
Email ____________ Cell Phone ____________
Driver's License # ____________ Birthdate ____________ Financial Institution ____________
Employer ____________ Work Phone ____________ SS#/SIN ____________
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured ____________ Relationship to Patient ____________
Birthdate ____________ SS#/SIN ____________ Date Employed ____________
Name of Employer ____________ Union or Local # ____________ Work Phone ____________
Address of Employer ____________ City ____________ State/Prov. ________ Zip/P.C. ________
Insurance Company ____________ Group # ____________ Policy/ID # ____________
Ins. Co. Address ____________ City ____________ State/Prov. ________ Zip/P.C. ________
How much is your deductible? ____________ How much have you used? ____________ Max. annual benefit ____________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ____________ Relationship to Patient ____________
Birthdate ____________ SS#/SIN ____________ Date Employed ____________
Name of Employer ____________ Union or Local # ____________ Work Phone ____________
Address of Employer ____________ City ____________ State/Prov. ________ Zip/P.C. ________
Insurance Company ____________ Group # ____________ Policy/ID # ____________
Ins. Co. Address ____________ City ____________ State/Prov. ________ Zip/P.C. ________
How much is your deductible? ____________ How much have you used? ____________ Max. annual benefit ____________

Over Please

Patient Medical History

Physician ______________ Office Phone ______________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ______________	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________ Date of Last Exam ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

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 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 payors 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 ______________

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

Doctor's Comments ______________

____

______________ Signature ______________ Date ______________

Megan A. Shiga, DDS, LLC

DENTAL INSURANCE AND FINANCIAL ARRANGEMENTS

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.

If you have dental insurance, we will work hard to help you receive your maximum allowable benefit. In order to achieve this goal, we need you to take the necessary steps to understanding your insurance plan. With there being so many different providers and plans, it is impossible for us to know all of our patients' benefits. It is very important for you as a dental insurance policy holder to be aware of the plan benefits, deductible and exclusions. Plan benefits can be obtained by calling your dental insurance company or logging on to their website (if available). We will gladly discuss your proposed treatment and answer any questions that you may have relating to your insurance. You, however, must be aware that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Most insurance companies have a yearly deductible that is your responsibility to pay.
3. Most insurance companies only pay a percentage of the cost (such as 50% or 80%) and you will be responsible for the remainder.
4. Not all services are a covered benefit in all contracts. It is important for you to contact your insurance provider and ask if there are any clauses or waiting periods.
5. As a courtesy to you, our office will submit claims to your insurance provider. If for any reason the claims go unpaid, you will be responsible for all charges.

If you have any questions regarding this information or any uncertainty about your insurance coverage, please don't hesitate to ask us. We are here to help you in any way we can.

I, ____________________, AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES ON MY ACCOUNT.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

SIGNATURE ________________________ DATE ________________

525 East Washington Street Chagrin Falls, OH 44022
drmeganshiga@yahoo.com   440-247-9220
www.chagrindentist.com

HIPAA & Office Policy Questionnaire

List names and dates of birth for all family members:

Name	Date of Birth	Name	Date of Birth
(Patient/Guardian)			

Sharing Medical Information
We will presume that you will allow us to share medical information with the following individuals unless you specify otherwise. Please place a check mark next to all of the following with whom you **DO NOT** wish us to share health information about you and your family.
If you do not allow us to share information with school, camp or daycare, please be advised that we are legally not allowed to fill out school, camp or daycare forms.

__Mother of Child	__Daycare	__Maternal Grandmother	__Camp
__Father of Child	__School	__Maternal Grandfather	__Other
__Step-Mother of Child	__Insurance Co.	__Paternal Grandmother	
__Step-Father of Child	__Pharmacies	__Paternal Grandfather	

Notice of Office Policies

- Our office gladly submits insurance claims on your behalf. Responsibility for the account remains that of the patient. A grace period of 60 days will be given for insurance purposes. If an unpaid insurance balance remains, the balance will then be due from the patient. The patient will receive reimbursement from the insurance carrier,
- Payment plans are available.
- An 18% monthly finance charge applies to any account over 90 days.
- A 24-hour notice for cancellation is greatly appreciated. Any cancellations received within 24 hours of the scheduled appointment will be subject to a **$75 cancellation fee**.
- Patients need to be aware of the terms of their dental insurance policy.

I acknowledge that on behalf of myself, or that of the above named children, I have received a copy of the **Notice of Privacy Practices and Office Policies** for Dr. Megan Shiga.

Print Name Signature Date