Stefanie Shore, DDS
Restorative & Esthetic Dentistry

New Patient Forms

Patients Without Dental Insurance

1) New Patient Information Form

2) Medical History Form

3) Dental History Form

4) Signature Sheet

Stefanie Shore, DDS
6660 Coyle Avenue, Suite 240
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(916) 966-4341

This information is confidential and is for Dr. Shore's records only. Please take a few moments to answer all questions completely and accurately. There are 4 parts to this form. Thank you.

PART 1	**PATIENT INFORMATION**					
PATIENT NAME:	(FIRST)	(INITIAL)	(LAST)			
HOME ADDRESS:	(STREET)		(CITY)		(ZIP)	
EMPLOYED BY:			Occupation:			
WORK ADDRESS:	(STREET)		(CITY)		(ZIP)	
BIRTHDATE:		HOME PHONE:	( )	WORK PHONE:	( )	
E-MAIL:				CELL PHONE:	( )	
SOC. SEC #:		IF FULL TIME STUDENT, NAME OF SCHOOL:				
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?						
INSURANCE:	(COMPANY)		(GROUP#)		(ID#)	

PART 2	**SPOUSE/PARTNER INFORMATION**			
SPOUSE'S NAME:	(FIRST)	(INITIAL)	(LAST)	
EMPLOYED BY:		OCCUPATION:		
WORK ADDRESS:	(STREET)	(CITY)		(ZIP)
WORK PHONE:	( )	CELL PHONE:	( )	
BIRTHDATE:		SOC. SEC #:		
INSURANCE:	(COMPANY)	(GROUP#)		(ID#)

PART 3	**PERSON FINANCIALLY RESPONSIBLE**				
	☐ *Check here if same as "patient" above* ☐ *Check here if same as "spouse" above*				
NAME:	(FIRST)	(INITIAL)	(LAST)		
HOME ADDRESS:	(STREET)		(CITY)		(ZIP)
EMPLOYED BY:					
WORK ADDRESS:	(STREET)		(CITY)		(ZIP)
WORK PHONE:	( )		CELL PHONE:	( )	
BIRTHDATE:		HOME PHONE:	( )		
SOC. SEC #:		HOME FAX:	( )		

PART 4	**CONSENT FOR TREATMENT OF A MINOR**

I, (parent/guardian name)_____, being the parent, guardian, or other person entitled to legal custody of (name of minor)_____, a minor child, do hereby authorize and consent to any x-rays, examination, anesthetic, or dental treatment to be rendered to said minor under the general or direct supervision of Stefanie Shore, DDS, as Dr. Shore deems necessary. This authorization will remain in effect unless Dr. Shore is notified by the parent or guardian.

Parent/guardian signature_____Date_____

MEDICAL HISTORY

Name _____ Date of Birth _____

1. Have you seen a medical doctor or been a patient in the hospital within the past two years? ☐ Yes ☐ No

If yes, for what problem? _____

2. Date of last complete physical examination _____ Kaiser Number: _____

3. Medical Doctor: Name: _____ Specialty _____ Phone # _____

Name: _____ Specialty _____ Phone # _____

4. Do you have now, or have you had in the past?:

	YES	NO		YES	NO		YES	NO
HEART ATTACK, DATE _____			ASTHMA			FAINTING OR DIZZY SPELLS		
HEART DISEASE OR FAILURE			TUBERCULOSIS (TB) / + SKIN TEST			PSYCHIATRIC TREATMENT		
ANGINA PECTORIS (CHEST PAIN)			ALLERGIES OR HIVES			CANCER OR TUMOR		
CONGENITAL HEART PROBLEM			SINUS TROUBLE			RADIATION OR CHEMOTHERAPY		
HEART OR ORGAN TRANSPLANT			DIABETES/HIGH BLOOD SUGAR			GLAUCOMA		
ENDOCARDITIS			THYROID PROBLEMS			ACID REFLUX/HEARTBURN/GERD		
BYPASS SURGERY/STENT			PINS/IMPLANTS/JOINT REPLACEMENT			ULCER (STOMACH OR INTESTINAL)		
HEART PACEMAKER / DEFIBRILLATOR			CORTISONE MEDICATION			AIDS, ARC OR HIV ANTIBODY +		
ARTIFICIAL HEART VALVE			ARTHRITIS			AUTOIMMUNE DISEASE		
HIGH BLOOD PRESSURE			BACK OR NECK PAIN			NEUROMUSCULAR DISEASE		
ANEMIA/OTHER BLOOD DISORDER			HERPES/COLD SORES/FEVER BLISTERS			KIDNEY/BLADDER TROUBLE		
EXCESSIVE BLEEDING			HEPATITIS/LIVER DISEASE			FOSAMAX/ACTONEL/BONIVA/ZOMETA		
STROKE, DATE_____			YELLOW JAUNDICE			OTHER BIPHOSPHONATES		
EMPHYSEMA			DRUG/ALCOHOL ADDICTION			OSTEOPOROSIS/OSTEOPENIA		
SHORTNESS OF BREATH			EPILEPSY OR SEIZURES			SURGERY		

5. Are you taking any medicines, drugs or pills of any kind? ☐ Yes ☐ No

Please list: _____ _____ _____

_____ _____ _____

6. Are you allergic to any drugs, medicines, latex or sulfites? ☐ Yes ☐ No

Name of substance: _____ Reaction: _____

_____ _____

7. Do you smoke or use smokeless tobacco? ☐ Yes ☐ No How much? _____

8. Do you have a disease, condition, or problem not listed above? ☐ Yes ☐ No List: _____

9. WOMEN: Are you pregnant? ☐ Yes ☐ No

Do you anticipate becoming pregnant? ☐ Yes ☐ No

Do you take birth control pills? ☐ Yes ☐ No

I have answered the above questions completely and accurately. I will inform my dentist of any change in my health or medicines at my next appointment.

_____ _____ _____

Signature of Patient, Parent or Guardian | Date | Reviewed By

Date	B.P.	Initials

Date	Change	Patient Initials	Staff Initials

DENTAL HISTORY

NAME:	DATE:
Last Dental Exam:	Last Dental X-Ray:
Last Dental Treatment:	
Last Dental Cleaning:	
What is your Immediate Dental Concern?	

PLEASE CHECK ALL ITEMS WHICH APPLY:

	YES	DOCTOR'S NOTES
Unhappy with the appearance of your teeth		
Unpleasant dental experiences/dental fears		
Preference for no anesthetic		
Problems with effectiveness of Local Anesthetic		
Orthodontic treatment: Age:		
Periodontal (Gum) surgery: Date:		
Deep Cleaning/Root Planing: Date:		
Bleeding gums		
Tooth/Teeth sensitive to temperature		
Tooth/Teeth sensitive to biting		
Teeth/Gums sensitive to instruments		
Difficulty eating some or all foods		
Bad breath/Unpleasant taste in your mouth		
Jaw problems (TMJ)		
Jaw has locked open or closed		
Clench or grind your teeth		
Pain/Stiffness in the jaw or neck		
Problems with dentures or partials		
Sore or lump in mouth for more than 2 weeks		
Diagnosed with Sleep Apnea		
Snoring		
Not feeling rested after 7-8 hours of sleep		

Reasons for lost teeth (circle): DECAY GUM DISEASE KNOCKED OUT
ORTHODONTICS WISDOM TEETH

Is there anything we can do to make your visit more pleasant?

_____

Other information about your dental history or needs?

_____

_____

In the event that you need dental treatment, is there another person (e.g. spouse, parent, etc.) who is involved in decisions regarding your healthcare and/or your financial decisions? Yes_____ No_____
If yes, please give their name and relationship to you:_____

Doctor Notes:

Stefanie Shore, DDS
6660 Coyle Avenue, Suite 240
Carmichael, CA 95608
(916) 966-4341

PATIENT'S NAME: _____

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FOR ALL PATIENTS:

1. I consent to the dental practice using my cell phone number to (choose one or both) □ call or □ text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.
   My cell phone number is: (____) _____

   Signature: _____ Date: _____

2. I consent to receiving from the dental practice email communications regarding treatment, insurance, my account and special promotions. I understand that I can withdraw my consent at any time.
   My email address is: _____

   Signature: _____ Date: _____

3. I acknowledge that I have been offered a copy of the Dental Materials Fact Sheet and the office's Notice of Privacy Practice.

   Signature: _____ Date: _____

4. I understand that I may be charged a 1.5% per month or 18% per year finance charge if my balance goes beyond 90 days.

   Signature: _____ Date: _____

5. I understand that I may be charged $25.00 per half hour of scheduled time if I miss an appointment or cancel without 2 business days notice. Also, I understand insurance will not cover the cost of failed appointments.

   Signature: _____ Date: _____

6. I understand that photographs may be taken as a record of my care, and may be used for educational purposes in lectures, demonstrations to other patients, and marketing efforts to include websites, publications and professional publications.

   Signature: _____ Date: _____