



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
 Carmichael, CA 95608
 (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			
<input type="checkbox"/> Check here if same as "patient" above <input type="checkbox"/> 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			
<p>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.</p> <p>Parent/guardian signature _____ Date _____</p>					

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
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PATIENT'S NAME: _____

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: _____