INFORMATION FORM

Date__________ How did you hear about Shine?________________________

PATIENT INFORMATION

1. Patient's Name_______________________________ Date of Birth ___/___/______ Gender: Male Female

2. Patient's Name_______________________________ Date of Birth ___/___/______ Gender: Male Female

3. Patient's Name_______________________________ Date of Birth ___/___/______ Gender: Male Female

4. Patient's Name_______________________________ Date of Birth ___/___/______ Gender: Male Female

Home Address: ___________________________________ City: _____________State: _____ Zip code: ___________

Phone #: (____) ______________________ What school do patients attend? ______________________________

LEGAL GUARDIAN INFORMATION

1. Legal Guardian's Name___________________________ Date of Birth ___/___/______ Cell #: (____)___________

Relationship to patient: (circle one) Father Mother Step-Parent Foster Parent Other______________________

Email Address: ____ Work Phone #: (____) __________________

Marital Status: Single Married Divorced Widowed Other Spouse's Name: ______________________________

Complete if different from patient:

Home Address: ___________________________________ City:_____________State: _____ Zip code: ___________

Phone #: (_____) ______________________________

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2. Legal Guardian's Name___________________________ Date of Birth ___/___/______ Cell #: (____)___________

Relationship to patient: (circle one) Father Mother Step-Parent Foster Parent Other______________________

Email Address: ____ Work Phone #: (____) __________________

Marital Status: Single Married Divorced Widowed Other Spouse's Name: ______________________________

Complete if different from patient:

Home Address: ___________________________________ City: _____________State: _____ Zip code: ___________

Phone #: (_____) ______________________________

EMERGENCY CONTACT

In case of an emergency in which parent(s) or legal guardian(s) cannot be reached, please provide a contact.

Name:_____________________________________ Relationship to Patient: ___________________________

Phone #: (______)______________________________

INFORMATION FORM

CAREGIVER CONSENT

Shine Orthodontics & Pediatric Dentistry requires a legal guardian to accompany children to their dental appointments. If a legal guardian is unable to be present, please provide names of caregivers or step-parent you give permission to make medical, dental, and financial decisions for the patient.

1. Caregiver's Name: ___________________________________ Relationship to Patient:__________________________
2. Caregiver's Name: ___________________________________ Relationship to Patient:__________________________

I, the legal guardian of _________________________, authorize the caregivers above to accompany and make medical/dental decisions as needed for the patient. I also accept all financial responsibility for any dental procedures completed under the caregiver's supervision.

_______________________________________ _______________________________________ ____________________

Printed Name of Legal Guardian **Signature** of Legal Guardian **Date**

INSURANCE INFORMATION

Primary Dental Insurance

Policy Holder's Name: _________________________________ Date of Birth ___/___/_______ SSN: __________________

Insurance Company: ___________________________________ Insurance Phone #: (_____)___________________________

Subscriber ID #: _______________________________________ Group #: ____

Secondary Dental Insurance

Policy Holder's Name: _________________________________ Date of Birth ___/___/_______ SSN: __________________

Insurance Company: ___________________________________ Insurance Phone #: (_____)___________________________

Subscriber ID #: _______________________________________ Group #: ____

Medicaid Insurance (AHCCCS)

Patient's Name: _____________________________ ID #: ____________________ Plan Name: ________________________

Patient's Name: _____________________________ ID #: ____________________ Plan Name: ________________________

Patient's Name: _____________________________ ID #: ____________________ Plan Name: ________________________

Patient's Name: _____________________________ ID #: ____________________ Plan Name: ________________________

INFORMATION FORM

DENTAL HISTORY

When was your last dental visit? ____

Name of previous dentist: ____

Do you have a concern with any of the following?

☐ Pain from teeth or mouth ☐ Injury to teeth or gums ☐ Crowded teeth

☐ Infection ☐ Poor brushing habit ☐ Finger, thumb, or pacifier habits

☐ Cavities ☐ Cold Sores/Canker Sores ☐ Grinding

If yes, please explain:

Patient Name/Concern: ____

Patient Name/Concern: ____

Patient Name/Concern: ____

Patient Name/Concern: ____

HIPAA ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Shine's **HIPAA Notice of Privacy Practices.**

______________________________	______________________________	__________________
Printed Name of Legal Guardian/Patient	**Signature** of Legal Guardian/Patient	**Date**

Relationship to Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Self ☐ Other:

Please Note: It is your right to refuse to sign this acknowledgement.

INFORMATION FORM

SHINE ORTHODONTIC & PEDIATRIC DENTISTRY POLICIES

Thank you for choosing Shine Orthodontics and Pediatric Dentistry as your dental home. These policies have been put in place for the privacy of our patients, and to ensure that financial payments are made, allowing us to continue to provide quality dental care for our patients. It is important that we work together to ensure that payment for services is as simple and straightforward as possible. Our practice manager and billing department will be glad to discuss these policies with you.

Please carefully read and initial by each statement, then sign below.

1. _____ **It is my responsibility to provide information necessary to process an insurance claim**. **Ultimately, it is up to me to know my insurance benefits.** As a courtesy, Shine will assist you in billing your insurance provider by submitting no more than two claims per date of service, on your behalf. It is your responsibility to notify Shine if there is a change in your insurance coverage, residence, or phone number. Treatment plans given in the office are always an estimate of what the insurance will cover, based on the information insurance has provided. Payment is due at the time of service regardless of who is accompanying the child.

2. _____ **I understand that minors must be accompanied by a responsible party, 18-years-old or older, to be treated at Shine.** If the child is present with someone other than a parent/guardian, we must have a copy of the appropriate legal documents and/or a signed Caregiver Consent Form.

3. _____ **I will call the office at least 48 business hours prior to my appointment to reschedule, if I am unable to keep my child's scheduled appointment.** I understand that failure to show up to my child's scheduled appointment constitutes as a NO SHOW, and a cancellation fee of $40 for routine appointments and up to $100 for dental treatment may apply.

4. _____ **I will turn off my cell phone during my appointment.** As the use of cell phones has grown, we have become aware of how they can interfere with communication between the patient and doctor, as well as patient privacy. Because of this, cell phone use is not permitted in patient areas. Thank you for your cooperation and understanding.

5. _____ **I understand there will be a charge of $20 for processing requests for records, made voluntarily by the patient or guardian**. The payment for completion of these forms will be collected at the time of request.

I have read and understand the policies of Shine Orthodontics and Pediatric Dentistry.

Printed Name of Legal Guardian/Patient	**Signature** of Legal Guardian/Patient	**Date**

INFORMATION FORM

MEDICAL HISTORY

Patient Name: Date of Birth:

Update Contact Info
Address: **Phone #:**

Question	Yes/No	If yes
Do you have a Physician, Pediatrician or Clinic? Please provide name.	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, vitmains, or drugs?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Are you up to date on all immunizations?	○ Yes ○ No	

Are you allergic to any of the following?

☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Metal
☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics	☐ Amoxicilin
☐ Other Allergy	☐ Clindamycin		

Do you use controlled substances? ○ Yes ○ No If yes

Have you ever had any serious illness not listed ? ○ Yes ○ No If yes

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

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
AIDS/HIV Positive	○ Yes ○ No	Hemophilia	○ Yes ○ No	Seasonal allergies	○ Yes ○ No	Diabetes	○ Yes ○ No
Hepatitis A	○ Yes ○ No	Anaphylaxis	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Disease	○ Yes ○ No
Anemia	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Rheumatoid arthritis	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No
Scarlet Fever	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No
Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No	Asthma/trouble breathing	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No
Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No
Kidney Problems	○ Yes ○ No	Blood Transfusion	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Bleed/Bruise Easily	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Cancer	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Tonsillitis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Ulcers	○ Yes ○ No	Convulsions	○ Yes ○ No
Heart Trouble/Disease	○ Yes ○ No	Behavioral Concerns	○ Yes ○ No	ADD/ADHD	○ Yes ○ No	Autism Spectrum	○ Yes ○ No
Autoimmune disease	○ Yes ○ No						

Explain:

Printed Name of Legal Guardian/Patient

Signature of Legal Guardian/Patient **Date**

Signature of Doctor **Date**