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 Employer: ____

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

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

Subscriber ID #: _______________________________________ Group #: ____

Secondary Dental Insurance Employer: ____

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 ☐ Crowded teeth ☐ Grinding

☐ Infection ☐ Poor brushing habit ☐ Other

☐ Cavities ☐ Cold Sores/Canker Sores

☐ Injury to teeth or gums ☐ Finger, thumb, or pacifier habits

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

POLICIES OF SHINE ORTHODONTICS & PEDIATRIC DENTISTRY

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 Shine with the information necessary to process insurance claims**. It is my responsibility to notify Shine if there is a change in 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. 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. **Ultimately, it is up to me to know my insurance benefits. 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 Shine at least 48 business hours prior to my appointment, 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 fee of $50 for routine appointments, and up to $200 for dental treatment may apply. At Shine, we are dedicated to the preventative care and treatment of our patients. When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation. When a patient fails to show up for an appointment, or to cancel within 48 hours of the appointment, our valuable resources are idle. More importantly, a patient care opportunity is missed.

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 $40 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. After payment is received, processing the records request takes up to 72 business hours.

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

Patient Name: Date of Birth:

Update Contact Info

Address: Phone #:

Question	Answer	
Do you have a Physician, pediatrician, or Clinic? Please provide name.	Yes O No O	
Have you ever been hospitalized or had a major operation?	Yes O No O	
Have you ever had a serious neck injury?	Yes O No O	
Are you taking any medications, vitamins, or drugs?	Yes O No O	
Are you on a special diet?	Yes O No O	
Are you up to date on all your immunizations?	Yes O No O	

Are you allergic to any of the following?

☐ Acrylic	☐ Codeine	☐ Metal	☐ Sulfa Drugs
☐ Amoxicillin	☐ Latex	☐ Peanuts	☐ Other Food/Nut
☐ Clindamycin Other Allergy	☐ Local Anesthetic	☐ Penicillin	☐ Other Allergy

If other, explain:

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

Heart & Blood
- AIDS/HIV Positive...... Yes O No O
- Anemia...................... Yes O No O
- Artificial Heart Valve Yes O No O
- Blood Disease........... Yes O No O
- Blood Transfusion..... Yes O No O
- Bruises Easily............ Yes O No O
- Congenital Disorder.. Yes O No O
- Diabetes/Hypoglycemia. Yes O No O
- Heart Disease........... Yes O No O
- Heart Murmur........... Yes O No O
- Heart Pace Maker..... Yes O No O
- Hemophilia................ Yes O No O
- High Blood Pressure.. Yes O No O
- High Cholesterol........ Yes O No O
- Irregular Heartbeat... Yes O No O
- Leukemia................... Yes O No O
- Low Blood Pressure.. Yes O No O
- Sickle Cell Disease.... Yes O No O

Behavioral & Neurological
- ADD/ADHD............... Yes O No O
- Autism Spectrum...... Yes O No O
- Behavioral Concerns Yes O No O
- Convulsions............... Yes O No O
- Epilepsy/Seizures...... Yes O No O
- Fainting/Dizziness..... Yes O No O

Liver Related
- Hepatitis A............... Yes O No O
- Hepatitis B or C......... Yes O No O
- Kidney Trouble.......... Yes O No O
- Liver Disease............ Yes O No O
- Renal Disease........... Yes O No O

Breathing & Lungs
- Anaphylaxis.............. Yes O No O
- Asthma..................... Yes O No O
- Breathing Trouble.... Yes O No O
- Bronchitis.................. Yes O No O
- Frequent Cough........ Yes O No O
- Hay Fever.................. Yes O No O
- Lung Disease............ Yes O No O
- Pneumonia............... Yes O No O
- Seasonal Allergies.... Yes O No O
- Sinus Trouble............ Yes O No O
- Tonsillitis.................. Yes O No O
- Tuberculosis............. Yes O No O

Musculoskeletal
- Arthritis/Gout.......... Yes O No O
- Jaw Pain.................... Yes O No O
- Rheumatic Fever....... Yes O No O
- Rheumatoid Arthritis.. Yes O No O

Other
- Autoimmune Disease Yes O No O
- Cancer........................ Yes O No O
- Cleft Palate.............. Yes O No O
- Cold Sores/Blisters.... Yes O No O
- Frequent Headaches Yes O No O
- Herpes........................ Yes O No O
- Hives/Rashes............ Yes O No O
- Premature Birth........ Yes O No O
- Scarlet Fever............. Yes O No O
- Thyroid Disease......... Yes O No O
- Tumors/Growths....... Yes O No O
- Ulcers......................... Yes O No O

Have you had any serious illness not listed? Yes O No O

Comments:

Printed Name of Legal Guardian/Patient

Signature of Legal Guardian/Patient **Date**

Signature of Doctor **Date**