SHANNON DENTAL HEALTH CENTER

Michael E. Shannon, D.M.D. Kenneth E. Breeden, D.D.S., D.O.

Welcome!

We are pleased to welcome you to our practice. We look forward to working with you to maintain your dental health.

Patient Information:

***Name: ________________________________ *Birthdate: ____/____/_______**

Address: ________________________________ *SS#: ______________________

City: ______________________ Zip:___________ Home Phone: (____) ____-_____

Email Address: ___________________________ **Cell Phone: (____) ____-_____

Employed By: ____________________________ Work Phone: (____) ____-_____

Spouse Name: ____________________________ SS#: _______________________

Employed by: ____________________________ Work Phone: (___)___-_________

Full-time student over the age of 18?______ School: ______________________

Does someone other than patient provide the insurance? Yes / No (circle one)

☐ **If divorced, please ask for the other responsible party info sheet.**

Primary Dental Insurance:

Policy Holder's Name: ______________________________ Birthdate: ____/____/____
Relation to Patient: ______________________________ SS#: ________________
Address:____
Home Phone: ___________ Work Phone: ___________ Cell Phone: ______________
Employed by: ____
Insurance Company:_______________________ Policy or Group#: _________________

Secondary Dental Insurance:

Policy Holder's Name: _____________________________ Birthdate: ____/____/____
Relation to Patient: ______________________________ SS#: _________________
Address:____
Home Phone: ___________ Work Phone: ___________ Cell Phone: ______________
Employed by: ____
Insurance Company:_______________________ Policy or Group#: __________________

Emergency Contact Name:

Name: _________________________ Work Phone:__________ Home Phone:___________
Relationship to patient: ____

Is there a specific person we should thank for referring you? ______________________

****Cell-Phone Notification:**

☐ Check here if you wish to be notified via cell phone text message, at the above listed cell number, 1-hour prior to your appointment.

I give my consent to have the necessary treatment recommend for the above patient after it has been mutually approved. If this account requires collection procedures or legal action, I will be responsible for all attorney and collection costs incurred. The venue for all legal action will be Benton County, WA.. **I understand that credit reports will be obtained**. I understand the proceeding information and I accept the financial responsibility of paying this account for all services provided, regardless of any supplementary forms of payment such as insurance. Unpaid balances will incur a service charge of 1.5% per month or 18% per year. Please be aware if you No-Show to your appointment or do not give 24hrs for cancellation there will be a $53.00 fee; this fee may be waived for extraordinary circumstances.

____ ______________________

Signature of Patient/Guarantor **Date**

***Required Information** ****Optional Consent to Cell Phone Notification**

We'll make you smile!

Michael E. Shannon, D.M.D.   Kenneth Breeden, D.D.S., D.O.

Your Name (Patient)

______________________________ Circle One: (Male) (Female)

Reason for today's visit

____

Shannon
Dental Health Center

Your current **dental** health is: Good Fair Poor

Are you currently in pain? Yes No

How many times a week do you floss? _____

When was your last dental exam? __________

Any previous dental surgery? Yes No

Type of surgery? ______________________

Do you consume breathmints/pop/candy (Circle)

How many times a day do you brush? _____

Do you smoke or chew tobacco? Yes No

Previous dental office? __________

When was your last cleaning? __________

Do you regularly chew gum? __________

Have you ever had a serious/difficult problem associated with dental work? Yes No (Circle)

Please explain: ______________________________

HAVE YOU NOTICED ANY OF THE FOLLOWING?

Teeth tender to chew on	Y	N	Recurring sores in/around mouth	Y	N
Discomfort in face, head, neck	Y	N	Jaw clicking or popping	Y	N
Food caught between teeth	Y	N	Grinding teeth day or night	Y	N
Bleeding or sore gums	Y	N	Swelling, lumps in mouth	Y	N
Sensitivity to sweets	Y	N	Sensitivity to hot or cold	Y	N

Your current **physical** health is: Good Fair Poor

Name of your current physician: Phone # ______________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Abnormal bleeding/ hemophilia	Y	N	Heart attack, heart murmur or angina	Y	N
Acid Reflux Disease	Y	N	Heart disease or treatment	Y	N
AIDS/HIV+	Y	N	Hepatitis A or B or C	Y	N
Anemic or Blood disorder	Y	N	Herpes, cold sores, or fever blisters	Y	N
Alcohol or drug abuse	Y	N	High or Low blood pressure	Y	N
Artificial valves/joints/implants	Y	N	Kidney disease or condition	Y	N
Are you on birth control or hormones	Y	N	Liver disease	Y	N
Blood thinner medication	Y	N	Lung problems or TB	Y	N
Breathing difficulties/Emphysema	Y	N	Nervous or Mental condition	Y	N
Cancer/Chemotherapy/ Radiation	Y	N	Pacemaker	Y	N
Digestive or Intestinal problems	Y	N	Rheumatic or Scarlet fever	Y	N
Diabetes/ Hypoglycemia	Y	N	Sexually transmitted disease	Y	N
Epilepsy/Seizures/Blackouts	Y	N	Sleep Apnea	Y	N
Glaucoma or Eye problems	Y	N	Stroke or Circulatory condition	Y	N
Face, Head or Neck Injury	Y	N	TMJ or Jaw joint pain	Y	N
Hayfever, Asthma or Allergies	Y	N	Thyroid Disease	Y	N
Severe or frequent headaches	Y	N	Tumors or Growths	Y	N

Other: ______________________________

Please circle if you have had any unfavorable reactions to the following:

Aspirin Codeine Anesthetics Novacaine Sedatives Penicillin Antibiotics Other:

Please explain the reaction______________________________

List any medications currently being taken:______________________________

WOMEN: Are you possibly pregnant? Yes No (week #) Are you nursing? Yes No Are you taking Oral Contraceptives? Yes No

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

Patient/Guarantor Signature______________________________ Date______________

SHANNON DENTAL HEALTH CENTER
800 N CENTER PARKWAY
KENNEWICK, WA 99336
(509) 783-0824

I understand that I am financially responsible for payment for services rendered by Shannon Dental Health Center regardless of coverage by my insurance carrier. Payment for services are due in full on the date of service if I do not carry dental insurance or within 30 days of the receipt of statement after my dental insurance carrier has paid unless other arrangement are made. If it becomes necessary to engage an attorney or collection agency, I will be responsible for those costs.

A 1.5% service charge will be added to my account balance after 30 days and each month thereafter. I understand that I am responsible for all service charges. If my account remains unpaid for 60 days, I understand that it may be sent to a collection agency. I understand that if my account becomes 60 days delinquent and is sent to collection, confidential and personal information about by account will be disclosed to the collection agency to be used for the sole purpose of collection on the unpaid charges. It is my responsibility to inform Shannon Dental Health Center if my address or phone number changes.

I understand that Shannon Dental Health Center has a written policy in place that safeguards the privacy and security of my private and personal dental information. This consent permits Shannon Dental Health Center to disclose and to exchange my personal dental information with my dental insurance carrier and others as necessary for treatment, payment and health care operations.

__________ **Please Initial**

NO SHOW / RESCHEDULE FEE POLICY

Shannon Dental Health Center has a No Show/Reschedule Fee. This fee is not a covered benefit with any insurance. The fee is the patient's/guarantor's sole responsibility.

No Show/Same Day Reschedule fees are as follows: $53 for an office visit. When time allows, we will reconfirm your appointment. Please do not rely on these courtesy calls.
The fee will be waived if a 24 hour notice is given prior to scheduled appointment time.

We realize circumstances beyond your control may arise, such cases will be reviewed and the fee may be waived depending on the situation.

__________ **Please Initial**

ACKNOWLEDGMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notices of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____ Date: ______________________________________

Signature: ____

Relationship to Patient: ____

Please list all dependent family members you wish to also be covered by this acknowledgment:

____

____

I also acknowledge that I have read and understand the No Show/Reschedule/and Financial responsibility policies. I also understand and have signed the Privacy Practices Policy.

Patient Signature: ____ Date: _____________________________________

Parent/Legal Guardian/Responsible Other Signature ____

Thank you for your cooperation, Shannon Dental Health Center.

(FHNSP 10/06/16)