

S.Yusuf Shere, D.D.S., M.S.

Diplomate of The American Board of Periodontology

Personal Information

Patient's Name _____ Today's Date _____
Nickname / Preferred Name (if any) _____ Birth Date _____ S.S.N. _____
Status (*please circle*): Child / Adult Single Married Divorced Widowed Parent's / Spouse Name: _____
Billing Address _____ City/State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-Mail Address _____
Best time to reach you? _____ Preferred method of contact? _____

Emergency Contact Information (*we only use in case of emergency*)

Name _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____

Employment

Employer _____ Job Title _____
Work Address _____ City/State _____ Zip _____
Spouse's Employer _____ Work Phone _____

Whom may we thank for referring you?

Name of referring DDS _____ Location _____
Did you hear about us in any other way? (*if yes, please explain*) _____

Dental Insurance

Insured's Name _____ Relationship to Patient _____
Insured's Birth Date _____ S.S.N. _____ Employer _____
Insurance Company's Name _____ Phone _____
Address _____ City/State _____ Zip _____

Secondary Insurance (*if applicable*)

Insured's Name _____ Relationship to Patient _____
Insured's Birth Date _____ S.S.N. _____ Employer _____
Insurance Company's Name _____ Phone _____
Address _____ City/State _____ Zip _____

By signing this, I authorize S. Yusuf Shere D.D.S., M.S. and staff, to release any patient record information needed to process benefit claims for me or my dependants and to submit claims on my (*or their*) behalf related to services I or my dependant have or will receive.

X _____
Signature (*patient, parent or guardian*) _____ Date _____

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Patient Health History

Name _____ Age _____ Birth Date _____
Name of Physician and Clinic _____ Physician's Phone _____
Emergency Contact Name _____ Contact's Phone _____

Please circle your response to the following questions

YES NO Have there been any changes to your health in the last year?
YES NO Are you currently under the care of a physician? If so, please explain: _____

YES NO Have you ever taken antibiotics before dental treatment?
YES NO Have you ever had unfavorable reactions to dental materials?
YES NO Are you taking any blood thinning medications?
YES NO Do you take cortisone or steroid medications?
YES NO Do you take aspirin?
YES NO Are you currently taking any other medications; prescription or non-prescription? If so,
Please list names (dosages, if known): _____

Are you allergic to any of the following? (please circle)

Penicillin Y/N Codeine Y/N Aspirin Y/N Latex Y/N Acrylic Y/N Metals or Jewelry Y/N
Local Anesthetics Y/N Sulfites/Wine Y/N Other Allergies: (please list) _____

Please mark Y or N in response to the following health conditions as they apply to you:

_____ Heart Murmur	_____ Respiratory Problems	_____ MS
_____ Mitral Valve Prolapse	_____ Anti-Coagulation therapy	_____ Epilepsy
_____ Rheumatic Fever	_____ Blood Disorder	_____ HIV Positive
_____ Heart Attack	_____ Anemia	_____ Hepatitis – Type ()
_____ Angina	_____ Excessive Bleeding	_____ Cancer
_____ Heart Disease/Arrhythmia	_____ Liver Disease	_____ Chemotherapy
_____ Stoke	_____ Diabetes	_____ Radiation
_____ Pacemaker	_____ Kidney Disease	_____ Cold Sores
_____ Artificial Joints	_____ Glaucoma	_____ Canker Sores
_____ Back Problems	_____ Ulcers	_____ Dry Mouth
_____ Arthritis	_____ Thyroid disease	_____ TMJ Pain
_____ Asthma	_____ Chemical Dependency	_____ Do you smoke?
_____ Tuberculosis	_____ Psychiatric care	_____ Do you chew tobacco?
_____ Artificial Heart Valves		

Women: Are you pregnant? _____ Due Date: _____ Are you nursing? _____
Have you ever had any serious illness not listed above? Y/N If yes, please explain: _____

X Signature (patient, parent or guardian) _____ Date _____
(For office use only) – Update Initials _____ Date _____ + Initials _____ Date _____

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X Signature of Doctor _____ Date _____

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Office Financial Policy & Important Information Regarding Your Dental Insurance

We would like our patients to be informed of our office financial policy. We are committed to providing you with the best possible care. Payments are expected at the time services are rendered. If you have dental insurance we are happy to help you receive your maximum allowable benefits. To maintain the practice operation and to prevent potential misunderstanding, we ask patients to accept and adhere to financial arrangements regarding their dental treatment.

We accept cash, personal checks, MasterCard, Visa, Discover and American Express. In addition, we offer an excellent third party financial payment plan for balances over \$500. Our office staff would be happy to provide you with more detailed information on this plan if you are interested. Returned checks will be subject to a \$30 bank processing fee.

If you have dental insurance, please provide us with complete insurance information and we will help you process your insurance claim for your reimbursement. In special instances, we accept assignment of insurance benefits. However, please be aware of the following:

1. Your insurance is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 45 days, we will require you to pay the balance due with cash, check, MasterCard, Visa, Discover or American Express.

We must emphasize that as dental care providers, our relationship is with you, the patient, not your insurance company. While filing the insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payments of your account. If such situations do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, please do not hesitate to ask us. We are here to assist you with any questions or concerns you may have.

I have read the policies described in this form. I agree to abide by the terms outlined. I understand and accept my financial responsibilities.

X _____
Signature of Responsible Party

Date