THE SHAWCENTER FOR DENTAL EXCELLENCE

Thank you for selecting The SHAW Center for Dental Excellence. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, we will be happy to help.

BRUCE M. SHAW, D.D.S. MAURICIO C. TIJERINO, D.M.D. TRACY C. SHAW, D.M.D.

DENTAL REGISTRATION AND HISTORY

Today's Date _____

Name _____ Social Security# _____

Address _____ City _____

State _____ Zip Code _____ Home Phone ( ) _____

Email Address _____ Cell Phone ( ) _____

Choice of contact ☐ Text ☐ E-mail ☐ Phone call ☐ Any ☐ Other _____

Sex ☐Male ☐Female Date of Birth _____ Age _____

☐Single ☐Married ☐Domestic Partners ☐Separated ☐Divorced ☐Widowed

Name of Spouse _____

Emergency Contact _____ Phone ( ) _____

Relationship _____

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Who may we thank for referring you? _____

DENTAL INSURANCE

Name of Insured _____ Social Security # _____

Relationship to Patient _____ Date of Birth of Insured _____

Insured Employed By _____

Name of Insurance Company _____

Phone of Insurance Company ( ) _____

Group # _____ Member ID # _____

DENTAL HISTORY

Reason for Today's Visit _____ Date of Last Dental Care_____

Date of Last Cleaning _____ Date of Last Dental X-rays_____

Do you have a specific dental problem? If so, please describe_____

Please check if you have had any of the following:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Braces
- ☐ Broken teeth/ broken fillings
- ☐ Clenching
- ☐ Facial Pain
- ☐ Food collection between teeth
- ☐ Grinding
- ☐ Gum treatment
- ☐ Headaches
- ☐ Jaw locking
- ☐ Joint Sounds (clicking/popping)
- ☐ Limited jaw motion
- ☐ Loose teeth
- ☐ Painful jaw
- ☐ Pain when biting/chewing
- ☐ Oral surgery
- ☐ Sensitivity to hot/cold/sweets
- ☐ Other: _____

COSMETIC EVALUATION

Are you happy with your smile? _____ Would you like to have whiter teeth? _____

Would you like to straighten your teeth? _____ Are you interested in porcelain veneers? _____

Would you like to learn about your options to replace missing teeth? _____

Have you had Botox/Dysport and/or Dermal Fillers (Juvederm/Restylane/Perlane/Radiesse) in the past? _____

Would you be interested? _____

What additional services would you like to learn about? Please check all that apply:

- ☐ Clenching/Grinding treatments
- ☐ Repairing broken/fractured teeth
- ☐ Replacing missing teeth/implants
- ☐ Straightening crowded teeth
- ☐ Teeth Whitening
- ☐ Veneers
- ☐ Smile Design
- ☐ Length/Fullness/Darkness of Eyelashes
- ☐ Facial Injectables/Fillers
- ☐ Improvement of facial fine lines/wrinkles
- ☐ Correcting facial asymmetries (eyebrows, lips, etc)
- ☐ Improving thin lips/lip lines
- ☐ Brow lift
- ☐ Other: _____

MEDICAL HISTORY

Physician's Name_____ Physician's Phone ( )_____

Date of Last Physical Exam_____

Have you ever had any of the following? (check boxes that apply):

Abnormal Bleeding	**Congenital Heart Defect**	Hemophilia	Shingles
Alcohol Abuse	Diabetes	Hepatitis A/B/C	Sinus Problems
Allergies	Difficulty Breathing	High Blood Pressure	Stroke
Anemia	Drug Abuse	HIV/AIDS	Swollen Neck Glands
Angina Pectoris	Emphysema	Immune Disorder	Thyroid Problems
Artificial Heart Valve	Epilepsy	**Joint Replacement**	Tuberculosis
Arthritis	Facial Surgery	Kidney Problems	
Asthma	Fainting spells	Liver Disease/Jaundice	**Women Only:**
Back Problems	Fever blisters	Low Blood Pressure	Are you taking Birth
Bisphosphonates	Gastric Ulcers	Mitral Valve Prolapse	Control Pills? Y N
Blood Disease	Glaucoma	Pace Maker	Are you pregnant? Y N
Cancer	Headaches/Migraines	Radiation Therapy	If yes, # of weeks? ____
Chemotherapy	**Heart Attack**	Rheumatic Fever	Are you nursing? Y N
Circulatory Problems	Heart Surgery	Seizures	

Surgeries_____

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

ALLERGIES

Aspirin Local Anesthetic Latex

Codeine Penicillin Sulfa Drugs

Other_____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I and/or spouse/dependent(s) have insurance coverage with _____(Ins. Co. Name) and assign directly to Bruce M. Shaw, D.D.S., P.A., Mauricio C. Tijerino, D.M.D., and Tracy C. Shaw, D.M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of my signature on all insurance submissions.

The above named doctors may use my or my minor/child's health information and may disclose such information to the above-named Insurance Company (ies) and there agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

FINANCIAL AGREEMENT

I acknowledge that payment is due to Bruce M. Shaw, D.D.S., P.A., Mauricio C. Tijerino, D.M.D. and/or Tracy C. Shaw, D.M.D. at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. Should the account be referred to an attorney for collection, I authorize attorney to obtain my credit report; and the undersigned shall pay reasonable attorney's fees and collection expenses. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____