Thank you for selecting The SHAW Center for Dental Excellence. We will strive to provide you the best possible dental care. To help us meet all you 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 # ______________________

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	□ Food collection between teeth	□ Limited jaw motion
□Bleeding gums	□ Grinding	□ Loose teeth
□ Braces	□ Gum treatment	□ Painful jaw
□Broken teeth/ broken fillings	□ Headaches	□Pain when biting/chewing
□ Clenching	□ Jaw locking	□ Oral surgery
□ Facial Pain	□ Joint Sounds (clicking/popping)	□ 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	□ Length/Fullness/Darkness of Eyelashes
□ Repairing broken/fractured teeth	□ Facial Injectables/Fillers
□ Replacing missing teeth/implants	□Improvement of facial fine lines/wrinkles
□Straightening crowded teeth	□Correcting facial asymmetries (eyebrows, lips, etc)
□ Teeth Whitening	□ Improving thin lips/lip lines
□ Veneers	□ Brow lift
□ Smile Design	□Other: ______________________________________

MEDICAL HISTORY

Physician's Name_______________________________ Physician's Phone ( )______________________

Date of Last Physical Exam________________________

Have you ever had any of the following? (circle all 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	**<u>Women Only:</u>**
☐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 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. I agree to pay for all collection cost, including reasonable attorney's fees/costs in the event it becomes necessary to file suit to effect payment. I understand that filling a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature ____ Date ____________________________

No Show, Cancellation & Financial Policy

Thank you for choosing The SHAW Center for your dental and cosmetic needs. We are committed to your treatment being successful. We accept cash, checks, VISA, MC, AMEX and Care Credit as payment.

Insurance Policy

As a convenience to our patients, we will submit and process claims to your respective dental insurance company. I understand that I am required to leave a credit card on file to pay any remaining balance after my insurance benefits have been received. A courtesy call will be made before processing any charges to my credit card. Initial ____

Cancellations

With all services, we request a 24 hour cancellation notice. A cancellation after 24 hours or a no show may result in a charge in the amount of $75.00. Initial ____

Returned Checks

I understand if my check is returned to The SHAW Center for any reason, I will be charged $25.00. The SHAW Center will notify me if this occurs and I agree to pay the original amount plus the additional $25.00 immediately upon request. Checks will no longer be accepted if a check should bounce for insufficient funds. Payment for insufficient funds must be paid with a credit card or cash only.
Initial ____

Medical Information

By completing a confidential Medical History form, I understand that I have provided the staff at The SHAW Center all the details of my medical condition(s). I understand it is important for the doctors and staff to know this information prior to any procedures. It is also my responsibility to inform The SHAW Center of any changes to my medical history. Initial ____

Patient Name (print)____________________________________ Date________________

Patient Signature ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

**** PLEASE READ ****

IMPORTANT INSURANCE INFORMATION

Your dental plan is designed to share in your dental care costs. It may not cover the total cost of your bill. Most dental plans cover between 50 to 80 percent of dental services and pay according to what they have established as "usual and customary" fee limits. Please keep in mind that even though these limits are called "customary," they may or may not reflect the fees that our office charges.

We do not participate with any dental insurance company; however, we do extend the courtesy of filing your dental insurance claim for you. We cannot predict what your level of coverage for a procedure will be. We can only estimate what your insurance company will cover. This is because all dental plans vary, even possibly when they are provided by the same employer.

Your dental plan may not cover certain procedures or preventative treatments that may eliminate the need for extensive dental work in the future. Your dental plan may only allow benefits for the least expensive treatment for a condition. For example, if a crown is recommended, your insurance company may only offer reimbursement for a large filling. The least expensive alternative is not always the best option. Be assured that the treatment suggested by our office is in your best interest.

Your insurance company will send a copy of your Explanation of Benefits (EOB) to you when we receive payment. Please review your EOB carefully, if you have any questions please contact our office or your insurance company. Because we will be accepting assignment of benefits directly from your dental insurance carrier, we ask that you provide the information below to allow us to bill your credit card for any charges not covered by your insurance company.

Billing Agreement From Patient.

After my dental insurance company has paid its portion of the dental services rendered to me at the office of Dr. Bruce Shaw, Dr. Mauricio Tijerino and Dr. Tracy C. Shaw, I, ______________________, hereby give my consent to that office to charge any outstanding balance to my credit card. This balance may include deductibles and denials as well as non-covered services.

Signature ____ Date ___________________________

Credit Card # ____ Expiration Date __________________

V-Code: _______________________