Welcome to Pinecrest Smiles This confidential information will help us prepare for your visit.

NAME ______________________________________
Mr Mrs Ms Rev Dr

I prefer to be addressed as _________________________

Birthdate ___/___/___ SS# ______-____-________

Address ______________________________________

_________________________________ Zip ________

❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Home # _________________Work # _______________

Cell # _________________

E-Mail ____

Employer _____________________________________

Address ____________________________________

Occupation _________________________________

We use an appointment reminder system that can send you convenient email or text messages. We may also call and if necessary leave brief voicemail messages.

If you would prefer NOT to receive routine reminders from us via certain methods, please indicate below:
❑ No Text Messages ❑No E-Mail ❑No Cell Phone
❑No Home Phone ❑No Work Phone

Whom may we thank for referring you to our office?

____

Family members seen as patients here:

____

Spouse's Name ________________________________

Birthdate ___/___/___ Work # ___________________

Cell # ____________________

Employer _____________________________________

Address ____________________________________

Occupation _________________________________

Account Information
❑I have Dental Insurance to cover a portion of my fees

Name on Account ❑Self ❑Spouse ❑Other

Preferred Payment Arrangements (please check one)
❑Cash or personal check at time of service
❑Visa, MasterCard, Amex or Discover at time of service
❑CareCredit

Please check one box in each section:

❑ I currently have no dental or jaw pain or sensitivity.
❑ I currently have some dental or jaw pain or sensitivity.

❑ My mouth is very comfortable.
❑ My mouth is moderately comfortable.
❑ My mouth is uncomfortable.

❑ I am satisfied with the appearance of my teeth.
❑ I am curious about changing the appearance of my teeth.
❑ I am not satisfied with the appearance of my teeth.

❑ I am aware of current dental treatment that I need.
❑ I am not aware that I need any dental treatment.

❑ I think my present state of dental health is excellent
❑ I think my present state of dental health is good
❑ I think my present state of dental health is fair
❑ I think my present state of dental health is poor

Concerns I see about achieving or maintaining excellent dental health are:
(If you select more than one of the following, please number them in order of significance with **#1** being that which is most significant for you at this time)

_____ I see no obstacles

_____ Time away from work or other obligations

_____ Fear of possible discomfort, pain or injections

_____ Fear because of past dental experiences

_____ The cost of treatment

_____ Other ________________________________

____

____

____

My current **MEDICAL** health is:

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you under the care of a physician? ❑ No ❑ Yes

Physician Name ____________________________________

Office location ____________________________________

Office telephone ____________________________________

List all medications you take (prescription and over counter)

____

____

Have you ever had any of the following:

❑Heart Attack	❑Heart Surgery	❑Mitral Valve Prolapse
❑Heart Murmur	❑Pacemaker	❑Rheumatic fever
❑Scarlet Fever	❑Hepatitis	❑Kidney Problems
❑Cancer	❑Chemotherapy	❑Radiation Treatment
❑HIV / Aids	❑Shingles	❑Artificial Joint
❑Fever Blisters	❑Cold Sores	❑Artificial Valve
❑Stroke	❑Sinus Trouble	❑Epilepsy / Seizures
❑Diabetes	❑Tuberculosis	❑Psychiatric Problems
❑Ulcers	❑Colitis	❑Drug/Alcohol Dependence
❑Anemia	❑Asthma	❑Hemophilia / Bleeding
❑Arthritis	❑Emphysema	❑Venereal Disease
❑Fainting	❑Glaucoma	❑Difficulty Breathing

❑Hospitalized ____________________________________

❑High / Low Blood Pressure

❑Blood Transfusion

❑Severe or Frequent Headaches ______________________

For Women:

Are you taking birth control pills ❑No ❑Yes

Are you pregnant ❑No ❑Yes

Are you nursing ❑No ❑Yes

❑NONE OF THE ABOVE APPLY TO ME

Are you allergic to, or have had difficulty with any of the following substances:

❑Penicillin	❑Tetracycline	❑Latex
❑Aspirin	❑Codeine	❑Dental Anesthetic
❑Sulfa	❑Erythromycin	

❑Other Drugs ____________________________________

____

The information provided is accurate & complete to the best of my knowledge. I authorize the doctor to take X-rays, make study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

Unless I check the box below, I give permission to publish or use in print or electronic media any of my clinical photographs, x-rays, diagnostic information and findings, in whole or in part for training, research or promotional purposes only provided my identity is not revealed. I understand I may withdraw this permission at any time by notifying Dr. Shapiro in writing.

❑ *Do not use my clinical information*

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

All past due amounts are assessed 2% per month

SIGNED ______________________DATE ______

Thank you for filling this form out completely. If you have questions regarding this form or any aspect of our dental practice please call us anytime.

Pinecrest Smiles
Dr. Arthur I. Shapiro 305.233.8000

Dental Insurance Information and Agreement

As a service to our valued patients WE SUBMIT TO ALL INSURANCE COMPANY PLANS AND FILE ALL INSURANCE CLAIMS FOR YOU ELECTRONICALLY.

A SIGNED AND COMPLETED INSURANCE FORM IS REQUIRED FOR OUR FILES

The responsibility of the insurance company is to you and it is important that you make sure that you are reimbursed properly. We will do our best to estimate your insurance benefits but due to the fact that every group can have customized policies it is impossible for us to determine with complete accuracy. Additionally, insurance companies can downgrade procedures lowering their reimbursement. We will do our very best to be certain that you receive all of the benefits due to you from your insurance carrier. If you have any questions please ask us.

I wish to have you file my claims electronically. I have read all above completely and agree to the arrangements as stated.

SIGNED ______________________DATE ______

www.PinecrestSmiles.com