PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT) Home Phone_____

Patient_____
Last Name First Name Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Spouse Name_____

Spouse Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security #_____ Spouse's Social Security #_____

Name of Dental Insurance Company_____ Group Number_____

In case of emergency, who should be notified?_____ Phone_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Insured's B/D _____

Physician's Name_____ Date of Last Physical_____

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

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ "A.I.D.S." or Other Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, what_____

_____

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time?_____ If so, what_____

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

For what conditions?_____

If patient is a child, what is his/her weight?_____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____

_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

Dear Patient,

In order to keep our professional fees from rising, we have installed a new computer program that will aid in billing, along with other valuable office duties, To ensure that all patient's information is current, please take a moment to update and complete the information below. Ask for the phone book if needed.

Account Information – Please Print

☐ Male ☐ Female ☐ Adult ☐ Minor ☐ Single ☐ Married ☐ Widow

Patient Name _____ Phone No. _____

Who is the person responsible for this account (Self, Parent, Guardian, Spouse etc.)?

Name_____ Relationship _____ Phone No. _____

Address _____

City _____ State _____ Zip _____

Social Security No. _____ MDL No. _____

(Responsible Person)

Employer _____ Phone No. _____

Address _____

City _____ State _____ Zip _____

Dental Insurance Acct. No._____

Secondary Insurance Acct. No._____

I understand and agree that any credit granted shall be paid promptly in accordance with the terms of this agreement, that the credit grantor may add one and a half percent (1.5%) per month to any balance owed, and in the event of default to pay reasonable collection charges and attorney fees.

_____ _____

Signature of person responsible Date

David R. Shelby, D.D.S., P.C.
628 South Ave West
Missoula, MT 59801
406-549-6323

FINANCIAL AGREEMENT

New patients are expected to pay in full at their first visit.

Please select one of the following two payment options.

☐ Payment in full at time of each service.
Cash or Check
Visa or Mastercard Credit Card

☐ I request that my insurance company be billed. I will pay my estimated co-payment today or on the day of service.

- I understand that all balances shall be subject to a service charge of up to 1 ¼% per month until paid in full.
- I assign my insurance benefits to Dr. David R. Shelby.
- I give my permission to disclose my personal data for treatment, account balance resolution, and other healthcare operations to appropriate agencies.
- I understand that this form is valid unless I cancel the authorization through written notice.
- I understand that I am personally responsible to pay all collections fees associated with my account, including reasonable attorney fees and reasonable agency fees. I understand that in the event my account is turned over to a third party collection agency, a collection fee in the amount of up to 50% of my total account balance will be added to my balance and that I am responsible to pay that amount.
- I understand that I am responsible for the total fee for services.
- I understand that submission of claims to my insurance company is a service provided to me by Dr. David R. Shelby. I am responsible for payment of the total fee for services.
- This document supersedes all financial arrangements.

Patient Name(s): _____ Date: _____

Patient, Parent or Guardian Signature: _____

Please let us know if you would like a copy of this form.

DR. DAVID R. SHELBY, DDS, PC

With this consent, David R. Shelby, DDS may call my home or other alternative locations and leave a message on voicemail or in person in reference to such items as appointment reminders, insurance items and any call pertaining to my ongoing care.

I wish to be contacted in the following manner (check all that apply):

Home Telephone:

- ☐ Okay to leave message with detailed information.
- ☐ Leave message with callback number only.

Work Telephone:

- ☐ Okay to leave message with detailed information.
- ☐ Leave message with callback number only.

Written Information:

- ☐ Okay to mail to my home address.
- ☐ Okay to mail to my work/office address.
- ☐ Okay to fax to this number.

Other _____

_____

_____

David R. Shelby, DDS, PC

David R. Shelby's Notice of Privacy Practices has been provided for my review. I understand that I am entitled to receive a paper copy of this notice at any time.

_____ _____

Patient/Guardian Signature Date

Privacy Practices Acknowledgement

ACKNOWLEDGEMENT FORM

Shelby Dental is very concerned about the protection of your health information. **Federal Law** is requiring all physician offices to have a signed privacy statement on file for every patient. In order to serve you we must have an existing Privacy Acknowledgement form on file. This law is intended to protect the privacy of your medical records.

Thank You

I have been given the opportunity to review the Notice of Privacy Practice.

Patient Name: _____ Birth Date: _____

Signature: _____ Date: _____

Patient's Personal Representative & Relationship _____

___ I do, ___ I do not give permission to leave detailed message on answering machine regarding appointments, results, billing and/or insurance issues or other pertinent information from Shelby Dental.

ASSIGNMENT AND RELEASE OF INFORMATION

NOTE: Insurance Pre-Authorization: It is the patient's responsibility to notify this office if your insurance carrier requires pre-authorization for any services. Assignment and Release of Information: I hereby authorize Shelby Dental to release any information acquired in the course of my examination and treatment to the insurance company. I also authorize payment directly to the physician. *By signing below, I recognize and accept responsibility for any balance remaining after payment of benefits.*

_____ _____ _____

Signature of Responsible Party Relationship to Patient Date

CONSENT TO TREAT

I also hereby request and consent to treatment and services reasonable and proper by today's standards provided by a provider of Shelby Dental and any employee acting under my provider's orders.

_____ _____ _____

Signature of Responsible Party Relationship to Patient Date

AGREEMENT

To induce Shelby Dental to perform procedures on me for which my insurance company will not pay Shelby Dental, I agree that when my insurance coverage ends or if it has not yet taken effect, or if my insurance does not cover the procedure, etc., I will pay Shelby Dental the regular procedure fee charged by Shelby Dental.

Sign:_____

Printed Name:_____

Date:_____

Thank you,

Shelby Dental

Appointment Cancellation Policy

Shelby Dental is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (406) 549-6323 by 4:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Thursday*.** If prior notification is not given, you will be charged **$20** for the missed appointment.

Please sign below to consent to these terms.

_____

Signature (Parent/Guardian if under 18)

_____

Date