BRISTOL HEIGHTS DENTAL

MICHAEL SHIPP, DMD

Welcome! Thank you for choosing our dental office for your dental needs. We look forward to providing you quality care in a relaxing atmosphere!

Today's Date:_____

PATIENT INFORMATION

Patient Name_____Preferred _____DOB _____
Address_____City_____State_____Zip_____
Male ___Female___ SSN _____Marital Status_____DL# _____
Home Phone: _____Cell _____Work _____
Employer_____E-mail_____
Referred By: □ mailer □ Insurance Company □ website
□Patient_____Other_____

FINANCIALLY RESPONSIBLE PARTY if different than patient

Name_____ Marital Status_____
Complete Address_____
Phone #'s Home _____Cell _____Work _____Ext _____
Date of Birth_____ Relationship to Patient_____
SSN:_____Employer_____
Occupation_____ E-mail Address:_____

Spouse/Other _____
Complete Address_____
Date of birth_____ Relationship to Patient_____
Phone #'s Home _____Cell _____Work _____Ext _____
SSN _____ Employer_____
Occupation_____Address _____
E-mail address_____ D.L. No._____

EMERGENCY / ALTERNATE CONTACT INFORMATION

Name of the nearest relative not living with you_____ Relationship_____
Address_____
_____Phone # _____

DENTAL INSURANCE INFORMATION

We know that understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different in its covered services. We request that you become familiar with your policy exclusions, limitations, deductibles and required co-payment and /or co-insurance.

OUR COURTESY SERVICE TO YOU INCLUDES:

1. Filing your insurance claim within 24 hours of your visit and requiring payment of your benefits to this office.
2. Assisting you in researching your dental insurance plan to determine available benefits.
3. Re-filing your insurance a second time within 45-60 Days.
4. Following the American Dental Association guidelines for coding procedures and filing insurance.

OUR EXPECTATIONS OF YOU AS THE OWNER OF THE POLICY:

1. Payment of fees not covered by your insurance plan is due at the time services are delivered/rendered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance company.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company doesn't pay our office with 65 days.
5. Keeping our office informed of any changes in your insurance coverage, home address, or employment.
6. Understanding that amounts and fees regarding treatment and insurance are estimated and are subject to change.

Insurance Company _____Phone _____

Insurance Address _____ Group # _____

Subscriber Name _____Employer _____

Subscriber D.O.B. _____ Subscribers ID No._____

2nd Insurance:Company_____Address _____Phone _____

Group#_____ Subscribers ID No._____

Subscriber Name _____Employer _____ DOB _____

Please have your insurance card(s) ready for us to make a copy to keep on file.

I authorize Dr. Michael Shipp and/or all associates to release to my insurance company information acquired in the course of my dental care. I authorize benefits to be paid directly to Bristol Heights Dental.

_____ _____

Signature of insured/subscriber, or legal guardian Date

Bristol Heights Dental

Financial Information

- **Payment is due in full at the time of service unless financial arrangements have been made in advance. For patients with insurance, co-pays and deductibles will be collected on the day services are rendered.**
- Estimated fees are extended for a period of (3) months from the date of the patient examination.
- As a courtesy to all our patients we extend the use of outside billing services, which offer a wide variety of interest-deferred payment options as well as long-term payment plans.
- Due to the complexity of insurance contents, **estimated amount(s) is/are not a guarantee of insurance benefits, or patient co-pay amounts**. Insurance benefits may be subject to, but not limited to, eligibility, plan maximums and limitations, and insurance fee schedules. Any account balance over 60 days will be subject to a 12% monthly service charge.
- There is a $35.00 service charge for checks that are returned unpaid.
- Patient, or financially responsible person(s), agrees to be responsible for the remaining balance plus attorney fees, court costs and a collection agency and/or attorney if it becomes necessary to collect a debt. In addition to these named fees, a collection fee of up to 50% may also be charged to any unpaid balance.
- This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial agreements or quality care, are null and void.

RESERVATION / APPOINTMENT INFORMATION

- I grant my permission to Michael Shipp, DMD or his assignees to telephone me at home or at my workplace to discuss matters related to this form or concerning appointments. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.
- I authorize Michael Shipp, DMD or his assignees to release financial information and treatment descriptions and information, either electronically, or by facsimile or in paper form to my insurance carrier or any related entitles that require such information to be submitted.
- We make every possible effort to get each patient in to see the doctor and/or his assistants/hygienist in a timely manner. To assist us in staying on schedule we ask for your prompt arrival at your scheduled time.
- I understand there may be a $35/hour fee for missed or cancelled appointments with less than 24-hours notice.

Thank you for reviewing this important information and respecting out business procedures. Our dental team is available Monday through Thursday to answer any questions you may have about your account, scheduling an appointment, or just to chat. We will do everything in our power to make your visit with us exceptional!

I have thoroughly read, completely understand, and agree to cooperate with and abide by the procedures outline above.

I acknowledge that I may request a copy of the "Office Privacy Policy" for Bristol Heights Dental if I so desire.

_____ _____

Name of patient, parent/legal guardian (please print) Date

_____

Signature of patient, parent/legal guardian

Bristol Heights Dental
MEDICAL/DENTAL HEALTH INFORMATION

Patient Name _____Date_____

MEDICATIONS

Are you taking any medications? ☐ Yes ☐ No **If yes, please list name of medication and reason**.

_____

_____

DENTAL HISTORY

Please mark appropriate box if you have any of the following:

	Yes	No		Yes	No		Yes	No
Bad breath	☐	☐	Grinding teeth	☐	☐	Periodontal treatment	☐	☐
Bleeding gums	☐	☐	Gums swollen/tender	☐	☐	Sensitive to cold	☐	☐
Blisters on lips/mouth	☐	☐	Jaw pain/tenderness	☐	☐	Sensitive to hot	☐	☐
Burning sensation on tongue	☐	☐	Lip/cheek biting	☐	☐	Sensitive to sweets	☐	☐
Chew on one side of mouth	☐	☐	Loose teeth	☐	☐	Sensitive when biting	☐	☐
Clicking/popping jaw	☐	☐	Mouth breathing	☐	☐	Sore/growths in mouth	☐	☐
Dry mouth	☐	☐	Orthodontic treatment	☐	☐	Use of tobacco	☐	☐
Fingernail biting	☐	☐	Pain around the ear	☐	☐	How often do you brush	_____	
						How often do you floss	_____	

MEDICAL HISTORY

Please mark appropriate box if you have any of the following:

	Yes	No		Yes	No		Yes	No
Aids/HIV	☐	☐	Epilepsy	☐	☐	Respiratory Disease	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Rheumatic Fever	☐	☐
Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Scarlet Fever	☐	☐
Artificial Heart Valves	☐	☐	Headaches	☐	☐	Shortness of Breath	☐	☐
Artificial Joints	☐	☐	Heart Murmur/pre-med?	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	Heart Problems	☐	☐	Skin Rash	☐	☐
Back problems	☐	☐	Hepatitis Type A B C__	☐	☐	Special Diet	☐	☐
Bleeding, abnormal	☐	☐	Herpes	☐	☐	Stroke	☐	☐
Blood Disease	☐	☐	High Blood Pressure	☐	☐	Swollen feet/ankles	☐	☐
Cancer_____	☐	☐	Fainting or Dizziness	☐	☐	Swollen Neck Glands	☐	☐
Chemical Dependency	☐	☐	Jaw Pain	☐	☐	Thyroid Problems	☐	☐
Chemotherapy	☐	☐	Kidney Diseases	☐	☐	Tonsillitis	☐	☐
Circulatory problems	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Congenital Heart Lesions	☐	☐	Low Blood Pressure	☐	☐	Tumor/growth	☐	☐
Cortisone Treatments	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcer	☐	☐
Cough, persistent or bloody	☐	☐	Nervous/Anxiety	☐	☐	Venereal Disease	☐	☐
Diabetes	☐	☐	Pacemaker	☐	☐	Weight Loss, unplanned	☐	☐
Depression	☐	☐	Pregnant/Nursing	☐	☐	Radiation Treatment	☐	☐

Any condition not listed above_____

ALLERGIES

☐ **None** ☐ **Aspirin** ☐ **Barbiturates (sleeping pills)** ☐ **Codeine** ☐ **Latex** ☐ **Local Anesthetic** ☐**Penicillin** ☐ **Sulfa** ☐ **Other**_____

Medical/Dental Health pg. 2

Patient Name_____
Reason for today's vistit_____
Date of last dental visit_____ Date of last dental x-rays_____
Are you under the care of a physician? □ Yes □ No If Yes, please explain:_____
Name of Physician_____ Phone Number_____
Do you require pre-medication for a medical condition? □ Yes □ No If Yes, with: _____
Have you ever taken any drug related to fen-phen? (Ionimin, Adipex, Fastin, Pondimin, & Redux) □ Yes □ No

CONSENT TO PROCEED

- I certify these answers are accurate and correct to my knowledge. Since the change of medical conditions/medications can affect dental treatment, I understand the importance of and agree to notify Dr. Michael Shipp and/or any associate/employee of any changes at any subsequent reservation/appointment.
- I authorize Dr. Michael Shipp and/or any associate/employee as he/she may designate, to perform necessary procedures to maintain my dental health or the dental health of a minor or other individual(s) I am responsible for. These procedures include, but are not limited to, arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.
- I understand that the administration of local anesthetic may cause an untoward reaction or side effect(s), which may include but are not limited to: Bruising, hematoma, cardiac stimulation, temporary or permanent numbness and muscle soreness. I understand that on rare occasion(s) needles break and surgical retrieval may be required.
- I understand that as part of dental treatment, including preventive procedures such as hygiene cleanings and basic dentistry including restorations of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissue may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek(s) or other oral tissue to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.
- I understand that as part of dental treatment items including, but not limited to, crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. The unusual situations may require a series of x-rays to be taken by the physician or hospital and may in rare cases, require bronchoscopy or other procedures to ensure safe removal.
- I do voluntarily assume all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hope of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child(ren). I acknowledge that the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.

_____	_____	_____
Patient Name/Legal Guardian (Print)	Signature of Patient/Legal Guardian	Date
_____	_____	_____
Witness Name (Please print)	Signature of Witness	Date