Steven S. Shaw., D.M.D., P.C.
163 Pleasant Ave.,
Portland, ME 04103
Tel:207-773-3794, Fax: 207-772-1011
Email: info@backcovedental.com

PATIENT INFORMATION

Personal Information:

First Name: _____ Last Name: _____ Preferred name: _____

Date of Birth: _____ Social Security Number: _____

If minor, parent's names: _____

Home phone: _____ Work phone: _____ Cell Phone: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ ☐ I would like to receive communication via e-mail

Referred to our office by: _____ Previous Dentist: _____

Emergency Contact: _____ Emergency Phone Number: _____

Insurance Information:

Primary Insurance Information: ❑ Not covered by dental insurance ❑ Covered by dental insurance

Subscriber's Name: _____ Relationship to Subscriber: _____

Social Security number: _____ Date of Birth: _____

Insurance Company: _____ Address: _____Phone number: _____

Group number: _____ ID Number: _____

Employer Name & Address: _____

Secondary Insurance Information (if applicable):

Subscriber's Name: _____ Relationship to Subscriber: _____

Social Security number: _____ Date of Birth: _____

Insurance Company: _____ Address: _____Phone number:_____

Group number: _____ ID Number: _____

Employer Name & Address: _____

Payment Methods:

It is our goal for our patients to understand their treatment needs as well as their financial responsibility before treatment begins. Therefore, we offer the following payment options:

1. Flexible payment plans of up to 12 months upon approval with Care Credit. Approval must be received prior to treatment date. Care Credit can be used for treatment over $200.00. Patients can apply online at www.carecredit.com.

2. We accept cash, personal checks, money orders, Visa, Mastercard, Discover, and American Express..

Office Policies:

Patients authorize this office to submit insurance claim forms on their behalf and provide information as needed to their insurance and understand that services offered are his/hers financial responsibility. It is the patient's responsibility to provide the correct insurance information at each visit. Patients should notify the office as soon as possible if there is a change in their insurance status. Payment in full is required at the time of service for all non-insured patients. Patients are responsible for any outstanding balances regardless of whether they have insurance or not. Insured patients are responsible for their *estimated* out of pocket costs, any co-pays or deductibles and any balances not covered by insurance at time of service.

Email communications: I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling: 207- 773-3794

Broken or missed appointments:

To reschedule or cancel an appointment, please notify us at least 24 hours in advance to avoid a missed appointment fee of $75.00 (fee is based on appointment length and/or number of appointments missed). Broken or missed appointments prevent other patients from receiving the dental care they deserve.

I have read and understand this document in its entirety; outlining our office policies and agree to these terms.

Signature of patient or parent/guardian: _____

Date: _____

Notice: Steven S. Shaw D.M.D., P.C., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, or age. If you speak English, the language assistance services are complimentary. **(French)**: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.**(Spanish)** : si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Time 11:55 AM | Steven S. Shaw, D.M.D. | Date 3/31/2022

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

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HIPAA ACKNOWLEDGEMENT FORM

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use of and disclosure of your protected health information. These rights are more fully described in our Notice of Privacy Practices, updated effective September 23, 2013 and contain a more complete description of the uses and disclosures of your health information.
This information can and will be used to:
-Conduct, plan and direct treatment and follow up care among the multiple healthcare providers who may be involved in the treatment, directly or indirectly.
-Obtain payment from designated third-party payers

You have been given the right to review our Notice of Privacy Practices prior to signing this consent. You understand that Steven S. Shaw DMD P.C. has the right to change its Notice of Privacy Practices from time to time and you may contact us at any time to obtain current copy of the Notice of Privacy Practices.
You may request in writing that we restrict how your private information is used or disclosed to carry out treatment, payment or health care operations. You also understand that Steven S Shaw DMD, P.C., is not required to agree to your requested restrictions, but if Steven S .Shaw DMD, P.C. does agree, then it is bound by such restrictions. You may revoke this consent in writing at any time, except to the extent that Steven S. Shaw DMD, P.C., has taken action relying on this consent.

Please ask our front desk associate for a copy if you would like one. There is also a framed copy on display in our waiting area.

I have received and read this organization's Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient:

Signature: _____ Date: _____

For office use only

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

- Individual refused to sign
- Communication barriers prohibit obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please specify)

_____