Health History **Shoop Dentistry**

Name ____ Date of Birth _____________

Phone Number (____) ______-__________Best time to call? _______ Address ________________________

City ________________________ State ________ Zip_____________ SSN __________________

Email ________________________________ Employed by ____________________________

Dental Insurance Company _________________Member ID_______________Are you the policy holder? yes/no

If not, who? ______________________ Policy Holder DOB__________ Policy holder SSN ________________

Do you have secondary insurance? yes/no Insurance Company ________________ Member ID ____________

Policy Holder Name _____________________ Policy Holder DOB_________ Policy holder SSN ____________

Emergency Contact _____________________ Phone (___) ____-______ How did you find us? ______________

Medical History

	Yes	No
Are you under a physician's care now?	☐	☐
Are you allergic to penicillin?	☐	☐
Are you allergic to latex?	☐	☐
Do you have any artificial joints or heart valve?	☐	☐
Have you had endocarditis?	☐	☐
Were you born with a congenital heart defect?	☐	☐
Have you ever taken bisphosphonates?	☐	☐
Do you use tobacco?	☐	☐
Substance abuse/Chemical dependency?	☐	☐
Females: Are you pregnant?	☐	☐

Please list all medications:

____

____

____

____

____

____

Please list any allergies:

____

____

Do you have a history of any of the following?

BP: /

☐ Abnormal Bleeding	☐ Blood Disease	☐ Diabetes	☐ Herpes	☐ Pacemaker
☐ AIDS/HIV	☐ Cancer	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Radiation
☐ Anemia	☐ Chemotherapy	☐ Heart Attack	☐ Kidney Disease	☐ Sinus Troubles
☐ Asthma	☐ Chest Pain	☐ Hepatitis	☐ Osteoporosis	☐ Tuberculosis

Please Explain: ____

Medical Doctor Name ______________________________ Phone (_______) _______-_______________

Dental History

Date of last dental visit ______________________ How often do you: Brush ___________ Floss______

Are you experiencing discomfort presently? Yes / No Explain: _________________________________

Do you wear a night guard? Yes / No Do you experience TMJ-D? Yes / No
Do you have missing teeth? Yes / No Do you want whiter teeth? Yes / No
Do you snore or have sleep apnea? Rate your sleep quality from 1-10 ________

Signature ____ Date ________________

TURN OVER

Shoop Dentistry Office & Payment Policy

700 S 320th St Suite E
Federal Way, WA 98003
P: (253) 946 – 3575

PATIENT'S NAME: ____
First M.I. Last

Welcome to Shoop Dentistry. The following is an outline of our Scheduling, Payment and HIPPA Policy. Please read it carefully:

APPOINTMENT CANCELLATIONS

- When time permits, as a courtesy, we will contact you to confirm your appointment. However, it is the responsibility of the patient to **keep or cancel** the appointment whether or not we were able to make contact for confirmation.
- **48 HOUR NOTICE** IS REQUIRED WHEN CANCELLING AN APPOINTMENT. FAILURE TO CANCEL IN TIME WILL RESULT IN A $50 FEE PER 1 HOUR APPOINTMENT.
- We will be unable to reschedule an appointment if you have three (3) or more broken appointments.

INSURANCE

- We will gladly file your insurance as a courtesy and accept assignment of benefits. However, if the insurance company does not pay after 60 days, it will be **your responsibility** to pay Shoop Dentistry for the services and resubmit for the insurance on your own.
- You are responsible for payment of any services applied to your deductible.
- You are responsible for payment of any amount over your annual maximum allowance which includes dental services performed in this office, as well as any other offices.

PAYMENT POLICY

- Total payment is due for services when treatment is rendered.
- There will be a 2% monthly service charge on any outstanding balances over 30 days.
- Should legal action be instituted to enforce payment for services rendered, the signer(s) agrees to pay court costs and/or reasonable attorney fees incurred by the holder in such action.
- There will be a $25.00 service charge on all returned checks.

HIPPA AUTHORIZATION

- My signature confirms I have been informed of my rights to privacy regarding my health information. I understand this information can and will be used to: Provide and coordinate my treatment among a number of health care providers who may wish to be involved in treatment directly or indirectly, obtain payment from third-party payers for my health care services, conduct normal health care operations such as quality assessment and improvement activities.
- I have been informed of my dental providers *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information and am entitled to a copy upon request.

Please inquire with our staff if you are uncertain about the subjects outlined above.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE POLICY.

PATIENT'S SIGNATURE: ____

(or legal Guardian) **SIGNATURE** **DATE**

TURN OVER