

Leslie J. Paris, D.D.S., M.S.D., P.C.

Diplomate, American Board of Periodontology

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Diplomate, American Board of Periodontology

Diplomate, International Congress of Oral Implantologists

PATIENT INFORMATION

Name: _____ Date: _____
Address: _____ Birth Date: _____ Age: _____
City/State/Zip _____ Male _____ Female _____ Marital Status: _____
Occupation: _____ E-mail address: _____
Employer: _____ Phone (H): _____ Phone (C): _____
Employment Address: _____ Phone (W) _____
Referring Dentist: _____ IN CASE OF EMERGENCY, PLEASE CONTACT: _____

Do you have dental insurance?

PERSON RESPONSIBLE FOR THIS ACCOUNT:

SPOUSE OR PARENT

Name: _____ Birth Date: _____
Employer: _____ Occupation: _____
Phone # _____

DENTAL INSURANCE INFORMATION

Insurance Company Name: _____ Insurance Group #: _____
Employee Name: _____ Employer Name: _____
Employee ID #: _____ Employee Birth Date: _____
Insurance Company Address _____ Relationship to Patient: _____
_____ Insurance Company Phone # _____

INSURANCE INFORMATION RELEASE:

I, the undersigned, have insurance coverage and assign directly to DR. PARIS and DR. SHUMAKER all dental benefits, if any, otherwise payable to me for services rendered. **I understand I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Date: _____ Signed: _____

DENTAL HISTORY

1. Chief complaint: _____
2. Have you had regular check-ups? _____
3. When was your last dental visit? _____
- 3a. What treatment was done then? _____
4. Do your gums bleed when brushing or flossing? _____
5. Have you lost many teeth? (If YES, why?) _____
6. Are you apprehensive about receiving dental treatment? _____
7. Any complications during previous dental treatments? _____

MEDICAL HISTORY

Referring Dentist _____

Patient Name _____ Date of Birth: _____ Age _____ E-mail Address _____

Name of family Physician: _____ Telephone # _____

Physician Address: _____

Are you in good health? _____ YES _____ NO **Do you have ANY health changes?** _____
Do you have, or have you had, any of the following? (Please circle)

Heart Disease	Seizures	Thyroid Disease	Lung Disease	Psychiatric Therapy
High Blood Pressure	Fainting	Anemia	Tuberculosis	Kidney Disease
Artificial Heart Valve	Arthritis	Blood Disease	Asthma/Emphysema	Veneral Disease
Reumatic Fever	Ulcers	Bleeding Disorder	Allergies	Joint Replacement
Heart Murmur	Tumor History	Hepatitis___	Sinus Trouble	Cough
Stroke	Radiation Therapy	Liver Disease	HIV/AIDS	Epilepsy
Diabetes	Chemotherapy	Bone Disease	Hysterectomy	Latex Allergy

Do you use alcohol? _____ Do you use tobacco? _____

YES NO Have you ever been hospitalized and/or had surgery? (If yes, please list most recent:)
When: _____ Why: _____
When: _____ Why: _____

YES NO Are you under the care of a physician now? Explain _____

YES NO Are you taking medication, drugs, pills, vitamins or herbal supplements? (If YES, list) _____

YES NO Are you allergic or sensitive to aspirin, penicillin, or any other drugs or medicine? Explain _____

YES NO Have you ever been treated for cancer with an I.V. drug like Zometa or Aredia?

YES NO Have you ever taken Fosomax or a bisphosphonate drug? If so, how long? _____ yrs _____ months

YES NO Do you have any disease, condition, or problem not listed above? (If YES, list) _____

YES NO Have you ever had any excessive bleeding requiring special treatment?

YES NO Have you ever had a blood test for hepatitis? If so, were you vaccinated? ___yes ___no

YES NO Have you had cankers or cold sores on your lips, tongue, gums or body?

YES NO If female, are you pregnant now? Delivery Date _____ Post Menopause? _____

YES NO If female, are you nursing?

YES NO Have you been out of the United States in the past 6 months? Where? _____

I consent to treatment as necessary or desirable to care of the patient first named above, for diagnosis of dental disease, deformity, or treatment of dental emergency. In case of dental emergency, I consent to treatment, as deemed necessary by the doctor, understanding the procedures will be explained in advance. I understand it is solely my responsibility to report any changes in the above information to this office. I consent to my x-rays and dental records being sent to my general dentist and my general dentist sending x-rays and dental records to Dr. Paris for her use.

Signed: _____ Date: _____
Patient/Parent/Guardian Leslie J. Paris D.D.S., M.S.D. / Nicholas D. Shumaker, D.D.S., M.S.

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Nicholas D. Shumaker, D.D.S., M.S.
970-207-4061

COMMITMENT TO APPOINTMENT

Your name in our appointment book is a bond of trust. It represents a mutually understood agreement that you will be present for your appointment and that we will be here to serve you. Our office is very firm in this regard, and we will not tolerate frequent cancellations or short notice changes. We certainly understand that, on occasion; circumstances do arise that prevent patients from keeping scheduled appointments. As a courtesy to our other patients, we kindly request two business days notice when rescheduling appointments. This will allow us time to fill your appointment with another patient. **Failed/no show appointments may be assessed a charge.** Patients who are more than 10 minutes late for their appointment may be rescheduled.

COMMITMENT TO FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

*Payment is due at the time of service.

*If insurance is involved, co-payment and any deductible are to be paid at the time services are rendered.

*Because every insurance plan is different, we do request full payment for initial/ new patient exams on the date of service.

We encourage you, the patient, to follow up on your insurance benefits, and delayed insurance payments. Insurance benefits are **not** a guarantee of payment. (We simply do not have the manpower to follow up on every insurance claim; and doing so would ultimately increase your dental costs.) **HOWEVER, IF YOUR INSURANCE COMPANY DOES NOT PAY THEIR PORTION WITHIN 60 DAYS OF THE DATE OF SERVICE YOU MAY BE ASSESSED A FINANCE CHARGE, WHICH WILL BE YOUR FINANCIAL RESPONSIBILITY. IF YOUR INSURANCE COMPANY DOES NOT PAY THEIR PORTION WITHIN 90 DAYS OF THE DATE OF SERVICE THE BALANCE IS DUE AND IS YOUR RESPONSIBILITY.**

**We accept cash, check, MasterCard, Visa, Discover, American Express and Care Credit.

Dental insurance should be regarded as dental assistance. It is designed to help you pay *some* of the cost of dental treatment. Because there are so many dental insurance companies and programs, it is nearly impossible for us to have complete knowledge of all of them. We will do our best to help you maximize your benefits. Dental insurance is meant to be a partial aid to defray professional fees. It is not designed to cover the entire cost of dental treatment.

Insurance is a contract between you and your insurance company. We are typically not a party to this contract. We file insurance as a *courtesy* to our patients. We are not required to become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, or other matters regarding reimbursement. The kind of benefits in your contract depends on what you or your employer has negotiated with the insurance carrier, and the amount of money that you choose to pay in premiums.

I understand that I am responsible for all costs of dental treatment regardless of what my insurance carrier may or may not pay.

Patient _____ Date _____