Address:
2711 Broadway Ave Slayton MN 56172

Phone #: 507-836-1000
Email: contact@shetekdental.com

Shetek Dental Care

INDIVIDUAL INFORMATION

Patient Name	Gender **M** **F**	If child, Name of *Responsible Party* Name:_____
Date of Birth Age _____-_____-_____ _____ _____	Social Security # _____-_____-_____	Address_____
Address_____ _____ZIP_____	Phone (Home)_____ (Cell)_____ (Work)_____	Phone_____ DOB_____ SS#_____ Driver's License#:_____
Driver's License #:	Marital Status: ○ Married ○ Single ○ Divorced ○ Other	
Whom may we thank for referring you to our office: _____	Would you like to receive correspondence via: ○ Text ○ Email Email Address: _____	

EMPLOYER INFORMATION

Employer Name:_____

Phone_____

Address_____

_____

EMERGENCY CONTACTS

1) NAME:_____

PHONE #:_____

2) NAME:_____

PHONE #:_____

Patient's Spouse Name (if applicable)_____

DENTAL INSURANCE INFORMATION

Please bring insurance card with to copy to your file

Name of Insured:	Insured ID #:	Insured Social Security #:	Group Number:	**Policy Holder DOB**:

Insurance Company	Ins. Co. Address	Ins. Co Phone#:

PROBLEMS OF THE JAW	Yes	No
CLICKING OF THE JAW		
PAIN Explain:_____		
DIFFICULTY OPENING OR CLOSING		
DIFFICUTLY CHEWING		
DENTISTRY AND SLEEP HABITS		
HAVE YOU BEEN DIAGNOSED WITH SLEEP APNEA?		
ARE YOU CURRENTLY USING A SLEEP APPLIANCE?		
ARE YOU SLEEPING WELL AT NIGHT?		
DO YOU SNORE?		
DENTAL CONCERNS		
DO YOU EVER AVOID A PART OF YOUR MOUTH WHILE EATING OR BRUSHING?		
DO YOU WEAR YOUR DENTURE/PARTIAL? Date it was made/placed:_____		
DO YOU SMOKE?		
DO YOU LIKE THE APPEARANCE OF YOUR TEETH?		
HOW WOULD YOU RATE YOUR SMILE 1-10?		
DO YOU HAVE ANY DENTAL FEARS?		
WHEN WAS YOUR LAST FUNCTIONAL BITE ASSESMENT?	Date:	

TEETH SENSITIVITIES:	Yes	No
HOT?		
COLD?		
SWEETS?		
BITING PRESSURE?		
DOES FOOD CATCH BETWEEN YOUR TEETH?		
DO YOUR GUMS BLEED WHILE BRUSHING?		
NOTICED ANY GUM SWELLING AROUND YOUR TEETH?		
HAVE AN UNPLEASANT TASTE/ODOR IN YOUR MOUTH?		
LAST DENTAL VISIT?		
PREVIOUS DENTIST?		

WHAT IS YOUR CHIEF DENTAL CONCERN?

ARE YOU CONCERNED ABOUT THE FINANCES REQUIRED FOR YOUR DENTAL HEALTH?

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

MEDICAL DOCTOR AND CLINIC NAME: _____

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

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ◯ 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 _____

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 _____ DATE _____

CONSENT FOR TREATMENT & AUTHORIZATION FOR RELEASE OF INFORMATION

Consent for Treatment: I do hereby voluntarily consent to Shetek Dental Care for dental care and treatment. Although this entity has agreed to provide me with the best care possible, I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examinations by this facility.
Authorization and Release: I certify that I have read and understand this information and have answered all questions truthfully and to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize my insurance company to pay directly to Shetek Dental Care any insurance benefits otherwise payable to me. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or practice has a contractual agreement with the plan prohibiting all or a portion of such charges.

**All patient accounts will be considered due upon date of service unless other financial arrangements have been made. As a courtesy to me, Shetek Dental Care will process my insurance if proper information is provided. I agree to pay my estimated portion and /or co pay on the date that services are rendered. Interest will be charged at a rate of 1.5% per month on all unpaid balances aged 30 days after date of service or 30 days after third party payer pays.

I have had full opportunity to read and consider the contents of this Consent form. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

SIGN: ____ **DATE** __________

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POLICY ON MINNESOTA HEALTH CARE PROGRAMS BENEFITS

Under Rule 101, The State of Minnesota allows dental clinics to limit the number of patients they see with Minnesota Health Care Programs (MHCP) benefits. Since the inception of our dental clinic, a policy has been in place to limit the patients we will see to maintain a MHCP patient mix at the State of Minnesota's allowed limit.
Because of the great demand for dental services from our existing patients with MHCP, on 12-01-2007 our office put in place new limits that restrict covered services to **existing active patients** with MHCP benefits currently in effect. We give notice to the Minnesota Department of Human Services that **we do limit acceptance of new MHCP patients.**

I________________________________, understand I was not an **existing active patient** with MHCP benefits in effect prior to 12-01-2007, or **my active patient status has lapsed**. Therefore, any dental services I choose to have completed by Shetek Dental Care will NOT be billed to any MHCP and I am fully responsible for the fees incurred.

Patient name:_______________________________________**Date:**_____________

Responsible Party signature:____________________**Staff Witness:**_________________

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

Patient's Name: (First Name, Last Name):	Date of Birth:

I understand that as part of my dental care, Shetek Dental Care creates and maintains health records that describe my health history, dental information, symptoms, examinations, test results, diagnosis, procedures, treatment, and plans for future care or treatment I may receive. I understand that health information collected and stored will be used for the following:

- To support my care and treatment at Shetek Dental Care (treatment)
- For continued treatment among health professionals who are involved and contribute to my health care (treatment)
- For billing purposes including information regarding my diagnosis, treatment, and services rendered (payment)
- For insurance claim processing by a third-party payers for verification of services billed (payment)
- A tool for routine healthcare operations such as assessing quality improvement (healthcare operations)

I understand that the Notice of Privacy Practices from Shetek Dental Care defines more information regarding the use and disclose of my protected health information as well as my rights to my health information. By signing this, I acknowledge that Shetek Dental Care has offered me a copy of their Notice of Privacy Practices. I acknowledge and understand the rights that I have over my protected health information. I authorize the use and disclosure of my protected health information as specified in the Notice of Privacy Practices. I authorize the use and disclosures for treatment, payment, and healthcare operations purposes for Shetek Dental Care.
I authorized Shetek Dental Care to communicate regarding my dental treatments to the following individual(s):
_____
_____

I understand that I am ultimately responsible for all charges incurred for dentistry performed at Shetek Dental Care office including balances left after insurance payment has been received.

I understand that Shetek Dental Care communicates through text messaging about appointment reminders that contain patient specific information. I agree to the communication through text messaging unless I select the box below.

☐ I do not wish to receive text message communication for appointment reminders (Check to Opt Out)

This consent will continue forever unless I cancel it by writing to: Shetek Dental Care, 2711 Broadway Ave, Slayton, MN 56172; if the consent is cancelled, it will not change releases that have already been made prior to the date of cancellation.

I understand that I can get an electronic copy of the Notice of Privacy Practices at www.shetekdental.com.

_____ _____
Patient's Signature/Legal Representative Signature Date (MM/DD/YYYY)

If Legal Representative, relationship to Patient (parent, guardian, ect) _____

Internal Use:

If patient refuses to sign, please have 2 staff members of Shetek Dental Care Sign Below:

_____ _____
Staff's Signature Staff's Signature
Reason for Refusal of Signature: _____