Shanna Lurie DDS, PA

We are pleased to welcome you to our practice.

Please fill out these forms for the information is essential for our staff to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to safely and efficiently protect your dental needs. Incorrect information can be dangerous to your health.

If you have any questions, we would be glad to help you. We look forward to working with you in maintaining good dental health.

Patient Information

Patient Name ______________________________________ _____________________________

Last Name First Name MI

Date of Birth: ____/_____/______ S.S. #:_____________________ Sex: M F

Address: __ __ __ __ __ __ __ __ __ __ __ __ __

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __

City State Zip Code

Home Phone:( )_ __ __ Cell:( )__ __ __ __ Work:( )_ ______________________

E-mail:____May we contact you: Yes_____ No_____

Emergency Contact: _______________ __ __ _________ Phone:( )_ _______ _______________

Patient's Employer __ __ __ __ __ __ __ __ __ __ __ _______

Spouse or Parent's Name: ________________________________ Phone:( )_______ __________

Out of State Address:_ __ __ __ __ __ __ __ __ __ __ _______

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __

City State Zip Code

Please list the months you reside in Florida: ____

Referred By: ________________________________

Person responsible for this account:__ __ __ __ __ __ __ _______ _______

Relationship to patient: __ __ __ __ __ __ __ __ _______

Do you have Dental/Medical Insurance? _ YES __ NO Phone No: ( )____ ____________________

Insurance Company:________________________ __

____

Group #: _______________ _____ Employer #: ______ _____________________

Ins. Address: _____________________________ __

____

City:__ __ __ __ __ __ State: __________ __ _______

Zip:______________

Employee / Subscriber's Name: ______ __

_______________________________________Relationship to patient: ____________

______Date of Birth: _________Subscriber's SSN: ____________________________

Address: ________________ __ __ __

________________________________ City: ________________________

____________ State: ________________ Zip: __________ Home Phone:

____

Subscriber's Employer: __________________________ Work Phone: (   )

Patient's Signature ________________________________ Date 1/14/2022

MEDICAL HISTORY

Name: ______________________, _______________________, _________ _____________________

Last First MI Social Security #

Are you in good health? Yes No

Are you under currently under the care of a physician? Yes No

If yes, please explain: ____

Physician's name:______________________________ Phone #__________________

Date of last visit:__________________

Are you taking any medications? Yes No

If yes, please list: ____

Do you take aspirin routinely? Yes No

Daily

Are you taking any blood thinning medications?

(Coumadin, Warfarin, Plavix, Vitamin E, dipyridamole, NSAIDs) Yes No

Have you taken other drugs not listed above in the past

6 months (such as steroids, cocaine, any over the counter

medications or herbal remedies or vitamins? Yes No

If yes, please list: ____

List over the counter medications/vitamins/herbal treatment you are taking now?

Have you had any serious illnesses or operations in the

last five years? Yes No

If yes, please describe:____

Have you ever had a blood transfusion? Yes No

If yes, please list dates: ____

Have your ever had a bad reaction to local anesthetic? Yes No

If yes, please describe:____

Have you ever been told to take antibiotic before dental treatment? Yes No

If so, why?____

Do you take, or have ever taken, Phen-Fen or Redux? Yes No

Do you take, or have ever taken medications to treat osteoporosis? Yes No

Please check box if you had or are now having any of the following:

- Anaphylaxis
- Anemia
- Arthritis
- Artificial heart valves
- Artificial joints
- Asthma
- Back problems
- Blood disease
- Cancer
- Circulatory problems
- Cortisone Treatments
- Congenital heart lesions
- Chemotherapy
- Diabetes
- Drastic weight loss
- Epilepsy
- Excessive bleeding
- Fainting
- Glaucoma
- Hard of hearing
- Headaches
- Heart murmur
- Heart problems
- Hemophilia
- Hepatitis
- High blood pressure
- HIV/AIDS
- Kidney disease
- Liver disease
- Mitral valve prolapse
- Pacemaker/defibrillator
- Radiation treatment
- Rheumatic fever
- Rheumatism
- Respiratory disease
- Scarlet fever
- Shortness of breath
- Sinus trouble
- Stroke
- Thyroid disease

Women

Are you pregnant? Yes No Maybe

Nursing? Yes No

Are you taking birth control pills? Yes No

Are you on Hormone Replacement medication? Yes No

If yes, please list:____________________________________

ALLERGIES

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Penicillin
- Tetracycline
- Clindamycin
- Sulfa Drugs
- Other __________________________

Do you have any other conditions, diseases, or problems not listed above? Yes No

If yes, please describe:____

Signature ___________________________________ Date 1/14/2022

DENTAL HISTORY

Why have you come to the dentist today?______________________________________

Have you had any serious trouble associated with any previous dental treatment? Yes No

Have you ever had an injury to your face, jaws or teeth? Yes No

Have you had any x-rays in the past 3 years? Yes No

Are you wearing dentures or partial dentures? Yes No

Do any of your teeth feel loose? Yes No

Are your teeth sensitive to Hot / Cold / Sweets? Yes No

Are you satisfied with the appearance of your SMILE? Yes No

Please check box if you have had or have in the present any of the following:

- Abscess in mouth
- Any food traps
- Bad breath
- Blisters Lip/Mouth
- Bleeding Gums
- Bad taste
- Missing teeth
- Lumps in or near mouth
- Difficulty chewing
- Dry mouth
- Burning Tongue
- Clenching/grinding teeth
- Cold sores
- Sensitive gums
- Pain jaw joint
- Clicking in jaw joint

How often do you see dentist?

- Every 3 months
- Every 6 months
- Every 9 months
- Yearly
- Emergency only

Please check if you have received any of the following:

- gum/periodontal treatment
- orthodontic treatment
- root canal/endodontic treatment
- wisdom tooth removal
- removal of other teeth

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Shanna Lurie and staff to help determine appropriate dental treatment. If there are any changes in my medical status, I will inform Dr. Shanna Lurie. Since at each visit a treatment plan will be presented and the work to be done will be explained to me before treatment is begun, I give Dr. Shanna Lurie my consent to perform any needed dental treatment and to use local anesthetic as needed.

I also give consent for the use of photographs for patient education purposes; my full name will not be included.

I agree ▪ I disagree ▪

Signature _________________________________ Date 1/14/2022

FINANCIAL POLICY

In an effort to keep fees reasonable and continue to provide quality care we are establishing the following payment policy.

1. All routine dental treatments **must** be paid in full at the time treatment is rendered.
2. Cash, checks, or credit cards are all acceptable forms of payment.
3. There is a $35.00 returned check fee.
4. We require payment of any non-covered services, deductibles or co-payments to be taken care of at the time of **each** appointment. For larger treatment plans you will be given an estimate of what your insurance company will pay and any co-payment will be handled according to the above financial policy.

____ I authorize my insurance company to pay to Dr. Lurie all insurance benefits otherwise payable to me for services rendered.

____ I authorize the use of this signature on all insurance submissions.

____ I authorize Dr. Lurie to release all information necessary to secure the payment of benefits.

____ **I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company.**

We hope this information has been helpful to you. Please feel free to ask our staff for

clarification on any questions you may have in regards to our services, billing, and insurance.

Signature ________________________________ Date 1/14/2022

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand, under the health insurance portability and accountability act of 1966 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:
Conduct, plan and direct treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
Obtain payments from a third-party payers.
Conduct normal healthcare operations such as quality assessment and physician certification.
I have received, read and understand your *notice of privacy practices*, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's *notice of privacy practices* and from time to time, I may contact this organization at the address above to obtain a copy of the *notice of private practices*.

I understand that I may request in writing that you review how my private information is used or disclosed to carry out treatment, payments or obtain care operations. I also understand you are not required to agree to my restrictions but if you do agree that you are bound told by such restrictions.

Patient's Name ________________________________

Guardian's Name (if minor) ______________________

Signature ________________________________ Date 1/14/2022