KEVIN A. SHUGARS, D.D.S.
PRACTICE LIMITED TO ENDODONTICS
1040 NORTH 10TH STREET, SUITE 230 (WEST POINT CENTER)
KALAMAZOO, MI 49009 (269-372-6333)

PATIENT #____________

PATIENT INFORMATION: (Confidential) **Date______________**

Patient (Mr. Ms. Mrs. Dr.)_______________________________________BirthDate______/______/______
Social Security #_______________________Home Phone_______________Cell Phone_________________
Address___________________________________ City________________State_______Zipcode__________
Check appropriate: Minor____Single____Married____Divorced____Widowed____Separated____
If Minor (Under 18), Responsible Person____________________SS#_______________Birthdate___/___/___
Address (if different from patient)_______________________City____________ST____Zipcode__________

PATIENT MEDICAL HISTORY:

Medical Physician_____________________________Physician Office Phone_________________________

	Yes	No	
1. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 year?	____	____	**If yes**, please explain__________________
2. Are you taking any medication(s) including Non-Prescription medicine?	____	____	**If yes**, please list medications___________
3. Are you under medical treatment now?	____	____	**If yes,** please explain__________________
4. Have you ever taken Phen-Fen/Redux? (weight-loss medication)	____	____	
5. Do you use tobacco?	____	____	
6. Do you use controlled substances?	____	____	
7. Are you wearing contact lenses	____	____	

Women only:
Are you pregnant?_________
Are you nursing?__________
Are you taking oral contraceptives? ___________

Do you have or have you had any of the following? (Please Circle) Other_________________

Heart Murmur	AIDS or HIV Infection	Thyroid Problem
Rheumatic Fever	Cardiac Pacemaker	Angina
Mitral Valve Prolapse	Frequently Tired	Anemia
Joint Replacement or Implant	Emphysema	Cancer
Heart Attack	Arthritis	Hepatitis/Jaundice
Heart Disease	Sexually Transmitted Disease	Stomach Troubles/Ulcers
High Blood Pressure	Chest Pains	Easily Winded
Swollen Ankles	Stroke	Hay Fever/Allergies
Fainting/Seizures	Tuberculosis	Radiation Therapy
Asthma	Glaucoma	Recent Weight Loss
Low Blood Pressure	Liver Disease	Respiratory Problems
Epilepsy/Convulsions	Leukemia	Diabetes
Kidney Diseases	Heart Trouble	**NONE OF THE ABOVE**

Are you allergic to or have you had any reactions to the following? (Please Circle)

Local Anesthetics	Penicillin	Other Antibiotics____________________
Sulfa Drugs	Barbiturates	Sedatives
Iodine	Aspirin	Any Metals (Nickel, Mercury, etc.)
Latex Rubber	Other________________	**NO KNOWN ALLERGIES**

Person to contact in case of Emergency___________________________________Phone _________________

PATIENT DENTAL HISTORY:

General Dentist______________________Referring Dentist or Doctor(if different)_______________________

Have you ever experienced any of the following problems in the jaw? (Please Circle)

Difficulty in chewing | Difficulty in opening and closing | NONE
Clicking | Pain (joint, ear, side of face)

Do you have pain?__________Where?_____________Does it keep you up at night?________________
What causes the pain? Chewing____Hot___ Cold____Sweets____
Have you had a traumatic injury to the area?_____ When?_____________________________________
When did the pain begin?______________________ Is it getting worse?______
Do you currently have a fever?_____ Do you have swollen glands (lymph nodes)?_________
Do you have swelling?_____ Have you had it before?___________ When?________________________
Is the tooth loose?_______

EMPLOYER:________________________________ PHONE #__________________________

STUDENT: YES OR NO (IF YES, WHERE____

DENTAL INSURANCE INFORMATION:

Primary Insured Name:____Birthdate____/____/____
Social Security Number______________________Employer__________________Phone #_______________
Insurance Company_________________________Insurance Company Phone _________________________
Insurance Company Address_________________________City________________State____Zipcode______
Group #_____________ Expected Co-payment (Patient Portion) Percentage_______%(Example: 80/20)

Additional **DENTAL** Insurance:

Secondary Insured Name:____Birthdate____/____/____
Social Security Number______________________Employer_______________________________________
Insurance Company_________________________Insurance Company Phone Number___________________
Insurance Company Address_________________________City________________State____Zipcode______
Group #_____________ Expected Co-payment (Patient Portion) Percentage_______%(Example: 80/20)

FINANCIAL POLICY:

It is our pleasure to welcome and thank you for selecting our endodontic office. As our patient, we value you and will strive to provide you with our best professional care, most advanced dental technology and gentle caring staff. Prior to your visit, we make every effort to inform you of the fees so that you can be prepared with payment in full or co-payments at **time of service**.

As a service to our patients, our office will bill your dental insurance carrier for services rendered in our office. Your dental insurance policy is a contract between you, your employer and the dental insurance company. You will be expected to pay for any charges that are not covered by your dental insurance, such as co-payments.

Our office policies regarding submitting and receiving insurance payments is as follows: It is your responsibility to contact the dental insurance company to determine your level of benefits. (Eligibility, coverage and percentage they will pay). The amount that the dental insurance company states they will pay is only an estimate. If your insurance pays less than expected, you will receive a statement from our office and the balance is due in 30 days. If your insurance company pays more than expected, you will receive an overpayment check from our office. **If the insurance company does not make payment by 90 days after the claim forms are sent, immediate responsibility for the payment is due and it will be your responsibility to follow up with the insurance company regarding any problems or delays you might be having with your claim.**

We gladly accept cash, check, debit card, mastercard, visa and discover. Please indicate below the method of payment that you will be using today. Thank you.

Cash______Check______Debit Card______MasterCard______Visa______Discover______

Please review the following consent. You will be required to sign it prior to initiation of treatment. This, however, does not commit you to treatment. This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable to aid in the chance of success of the planned endodontic therapy performed by Dr. Shugars with my permission. I agree to the use of local anesthesia if Dr. Shugars finds it necessary to aid in pain control during the procedure. POSSIBLE COMPLICATIONS OF ROOT CANAL THERAPY, ANESTHESIA OR SURGICAL ROOT CANAL THERAPY MAY INCLUDE SWELLING, TRISMUS (RESTRICTED JAW OPENING), INFECTION, BLEEDING, SINUS INVOLVEMENT, AND NUMBNESS OR TINGLING OF THE LIP, GUM OR TONGUE, WHICH RARELY OCCURS AND EVEN MORE RARELY IS PERMANENT.

I understand root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Due to the local conditions of the tooth and surrounding tissues, and sometimes due to the patient's general health, it may be impossible to successfully treat your tooth. On rare occasions, a tooth which has had root canal therapy may require retreatment, surgical correction or even extraction. During treatment there is a possibility of instrument separation within the root canals, perforations (extra opening made in the tooth), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure while locating the canals, and fractured teeth. **I also understand that only the root canal treatment is to be performed in this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be done by my regular dentist**. The other treatment choices, besides root canal therapy, include no treatment, waiting for more definitive symptoms to develop or tooth extraction. Risks involved in those choices might include but are not limited to pain, infection, swelling, loss of tooth, and infection in other areas. If I am under the care of Dr. Shugars, I understand that it is my responsibility to report any problems pertaining to the tooth (teeth) being treated, or medication prescribed to Dr. Shugars. I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

AUTHORIZATION AND RELEASE:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____Date__________________

Signature of patient (or responsible person, if minor)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,____have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Relationship to Patient   Patient Name   Date

For Office Use Only

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

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

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