**Patient Information**

Date________________________________

Name_________________________________________________________Male_____Female____

Address___________________________________________________________________________

Telephone: HM____________________ Cell_______________________ Work________________

Email:_____________________________________________________________________________

Date of birth:____________________________________SSN:_______________________________

Single___ Married___ Widowed___ Separated___ Divorced___ Partnered____ Minor___

Occupation________________________________________________________________________

Who may we thank for referring you?___________________________________________________

Personal contact in case of an emergency:

Name_________________________________ Relationship_________________________________

Phone:__________________________________

**Responsible Party** ______________________________________________________________

**Dental insurance**

Subscriber_________________________________________________________________________

Subscriber Date of Birth__________________SSN /Subscriber ID_____________________________

Relationship to patient__________________Subscriber employer____________________________

Primary Dental Insurance:____________________________________________________________

Address:__________________________________________________________________________

Phone:________________________________Group number______________________________

Secondary Insurance:__________________________________________________________

Address:___________________________________________________________________

Phone:__________________________________Group number_______________________________

**Authorization:** I hereby authorize Dr. Michael Shields to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on these pages and the dental/medical histories are correct to the best of my knowledge. I release Dr Michael Shields the right to release my dental and/or medical history and other information about my dental treatment to third party payors and/or other health professionals.

______________________________________________________________________________

Signature of Patient or Responsible Party Date

**General Financial consent**

I understand that I am responsible for all costs of the dental treatment. I understand that if I do not pay the entire account balance within 60 days of the monthly billing date, a service charge and/or rebilling fee may be added to the account for the current monthly billing. I understand that if a check is returned to our bank, I will be assessed $30 processing fee. We reserve the right to charge $30 for any missed or broken appointment without a 24 hour notice.

_____________________________________________________________________________________

Signature Date

**For our patients with Dental Insurance**

We will happily submit your insurance claim for you with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service**. I authorize payment directly to Dr Michael Shields for insurance benefits otherwise payable to me.** PLEASE NOTE: Although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company. Your dental insurance is a contract between you, your employer and the insurance company. Depending on your specific plan, your dental insurance may not cover our office dental fees for services rendered. The difference between our office dental fees and your insurance reimbursement is your responsibility. The entire balance is due within 60 days of treatment date of service.

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Signature Date

Help us understand how we can best help you:

What are you looking for in a dentist?__________________________________________________________

_____________________________________________________________________________________

What caused you to leave your last dentist?_____________________________________________________

_____________________________________________________________________________________

What quality of dentistry do you want us to recommend?

_____Ideal/ Best we can provide _____ Average ____ "Just patch it"

At what point do you want us to initiate treatment for you?

____When something isn't ideal _____When something worsens _____When my tooth hurts/breaks

**Do you have any upcoming events of circumstances we should/need to know about?**___Yes ____No

What?_____________________________________________________ When?______________________