10233. E. Northwest Hwy.
Suite 510
Dallas TX 75238
(214)340-4965
sandy@drshatto.com

American Family Dental

www.drshatto.com

PATIENT INFORMATION

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

◯ Internet ◯ Patient ◯ Yellow Pages ◯ Other

Name of person, office, or other source referring you to our practice:

_____

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MEDICAL HISTORY

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for you overall health and well-being.

Your Primary Care Physician's name, address & phone number:

Date of your last medical exam?

Please mark any of the following to indicate Yes in response to the question:

- ☐ Are you currently in good health?
- ☐ Within the last year, has there been any changes in your general health?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you ever had complications following dental treatment?
- ☐ Have you ever had any serious illness, operations or been hospitalized?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Recreational Drug use (i.e., marijuana, pain killers, IV drugs, etc)
- ☐ Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder?
- ☐ Do you wish to speak to the doctor privately about anything?
- ☐ Women: Are you pregnant or is there any chance you might be pregnant?

If any of the previous questions are marked, please explain:

Do you have or have you ever had any of the following? Please check those that apply:

☐ Anemia	☐ Growths	☐ Mital Valve Prolapse	☐ Stomach/GI Problems
☐ Arthritis	☐ Hay Fever	☐ Rhuematic Fever	☐ Thyroid Problems
☐ Artificial Joints	☐ Heart Murmur	☐ Rhuematism	☐ Ulcers
☐ Glaucoma	☐ Jaundice	☐ Sinus Problems	

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- [ ] Allergy-Amoxicillin
- [ ] Allergy-Anesthetic
- [ ] Allergy-Aspirin
- [ ] Allergy-Cinnamon
- [ ] Allergy-Clindamycin
- [ ] Allergy-Codeine
- [ ] Allergy-Erythromycin
- [ ] Allergy-Ibuprofen
- [ ] Allergy-Latex
- [ ] Allergy-Metals
- [ ] Allergy-Other
- [ ] Allergy-Penicillin
- [ ] Allergy-Sulfa
- [ ] Allergy-Tylenol
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Diabetes
- [ ] Dizziness/Fainting
- [ ] Endocarditis
- [ ] Epilepsy/Seizures
- [ ] Excessive Bleeding
- [ ] Head Injury
- [ ] Heart Disease/Attack
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV / AIDS
- [ ] Immune Disorders
- [ ] Implants
- [ ] Jaw Pain
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Nervous Disorders
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] ProstheticHeartValve
- [ ] PsychiatricTreatment
- [ ] Radiation Treatment
- [ ] Shortness of Breath
- [ ] Stroke
- [ ] Transplant-Heart
- [ ] Transplant-Other
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Venereal Disease
- [ ] x Other x

Do you have any other health issues or allergies?

MEDICATIONS: Are you currently taking any of the following? Please check those that apply:

- [ ] Antibiotics
- [ ] Blood Thinners
- [ ] Heart Medications
- [ ] Aspirin, Motrin, Aleve, etc
- [ ] High Blood Pressure Meds
- [ ] Insulin
- [ ] Oral Anti-Diabetic Drugs
- [ ] Tranquilizers/Anti-Depressants
- [ ] Bisphosphonates (Fosomax, Actenol)
- [ ] (Boniva, Aredia, Zometa, etc)

Please list any and all medications you are currently taking:

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DENTAL HISTORY

What is the reason for your dental visit today?

Your prior Dentist's name, address & phone number:

Date of your last dental exam?

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2 - 6 weekly ○ 1 - 6 monthly ○ Seldom ○ Never

Please check if you have experienced any of the following:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are checked, please explain:

I understand the importance of a truthful medical history. I realize that incomplete information may have an adverse effect on my treatment. I have read and understand the questions and I have answered them truthfully. I will not hold Dr. Cary Shatto or any member of his staff responsible for any errors or ommissions that I may have made in completion of this form.

Signature: _____ Date:

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..... CONSENT FOR SERVICES AND OFFICE POLICIES .....

I hereby authorized Dr Shatto and/or his staff to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs. I also authorize Dr Shatto to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with patient and further authorize and consent the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agent embodies a certain risk. For minor consent, I do hereby request and authorize the dental staff to perform necessary dental services for my child and perform administrations of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

..... AUTHORIZATION OF SIGNATURE & RELEASE OF INFORMATION AND RESPONSIBILITY .....

I understand and agree that I am responsible for all charges incurred in this office regardless of my insurance coverage. I understand that Dr. Shatto and Staff have accepted the estimate of benefits from my insurance company with good faith that the claims will be covered as described by my insurance company. I agree that any and all charges not paid by my insurance company within 90 days of service will be paid in full by me. I hereby authorize release of any information for all claims submitted for my dependants or myself.

I hereby assign and authorize payment of all dental benefits otherwise payable to me, directly to the office of Cary A Shatto, D.D.S. My signature below and any photocopy shall authorize payment to the dentist for any treatment rendered to my dependants or myself.

..... 24hr CANCELLATION / NO SHOW POLICY .....

I understand that if I need to cancel or break my appointment that I must do so within 24 hours of my appointment time or I will be charged $50.00 per scheduled hour.

..... CONSENT FOR OFFICE PHOTOGRAPHS .....

Do you grant permission for Cary A Shatto, DDS and/or his staff to use your before and after photos for the following:
1) Office Photo Album 2) Website/Internet Advertising 3) Printed or Internal Advertising

◯ Yes ◯ No

Signature: _____ Date: _____

Response Date: _____

American Family Dental

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change our privacy practices, we will change this Notice available upon request

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of the Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSUES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our **Healthcare Operations**. This include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs , accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health for treatment, payment or healthcare operations, you may give us written authorization to use your health information for treatment, payment or healthcare operations; you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patients Rights section of the Notice. We may disclose health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the information of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use a disclosure of your health information, we will provide you with the opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose your health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-ray, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are

American Family Dental

Cary A. Shatto, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____

Please Print Name

_____

Signature

_____

Date

Please provide names of who we can release patient information to

Name_____

Relation_____

Cell Phone_____

Name_____

Relation_____

Cell Phone_____

Name_____

Relation_____

Cell Phone_____