



Shape Dental

4881 Williams Drive, Suite-207

Georgetown, TX 78633

512-522-9922

Patient Information (Please print)

Patient's Name: Last _____ First: _____ MI _____

Date of birth: _____ SSN: _____ Sex: M I F

Phone Number: _____ Email address: _____

Home Address: _____

City, State and Zip: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Reason For Today's Visit: _____

Whom may we thank for referring you _____

If the patient is not responsible for payment of this account please complete following Information:

Responsible Party Information

Last: _____ First: _____ Martial Status: _____

Address: _____ City: _____ Zip Code: _____

Drivers License: _____ State: _____ DOB: _____ SSN: _____

Home Phone: _____ Cell Phone _____ Work Phone: _____

Employer: _____ Occupation: _____

RelationshipTo Patient: _____

Insurance Information

Policy Holder's Name: _____ SSN: _____ DOB: _____

Insurance Company: _____ Phone: _____

Insurance Company Address: _____

Policy ID# _____ Group #: _____

X _____ Date: _____
(Patient signature/ Parent or Guardian signature)

Patient Medical History

Patient Name: _____ DOB: _____ Date: _____.

Although General Dentistry primarily treats the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or may be taking, could have an important interrelationship with the treatment that you will be receiving. Thank you for answering the following questions.

Last Dental Visit: _____ Do your gums feel tender or irritated? Yes I No

Are your teeth sensitive to hot, cold, sweet or pressure? Yes I No

Physicians name: _____ Phone number: _____.

Are you under the care of a physician: Yes I No

If so, what conditions for: _____.

Are you currently taking any medications? If so please list them or provide a medication list:

_____.

Do you use Tobacco: Yes I No

If female, are you pregnant : Yes I No If so how many months? _____ Due Date: _____.

History of Joint Replacement: Yes I No

Have you been instructed to take premedication's for joint replacement, heart conditions or any other conditions? Yes I No

Mark any of the following medical conditions that have had or currently have:

☐ Aids/HIV ☐ Cortisone Medicine ☐ Heart Murmur ☐ Osteoporosis ☐ Alzheimer's Disease
☐ Diabetes ☐ Heart pacemaker ☐ Pain Jaw Joints ☐ Anaphylaxis ☐ Emphysema
☐ Heart Trouble/ Disease ☐ Radiation treatment ☐ Anemia ☐ Epilepsy/ Seizures ☐
☐ Hemophilia ☐ Rheumatism fever ☐ Arthritis/ Gout ☐ Excessive bleeding ☐ Hepatitis A, B or C

☐ Asthma ☐ Excessive Thirst ☐ High blood pressure ☐ Scarlet fever ☐ Blood Disease ☐ Stroke
☐ Fainting/ Dizziness ☐ High Cholesterol ☐ Sickle cell disease ☐ Blood Transfusion ☐ Ulcers
☐ Frequent Cough ☐ Hypoglycemia ☐ Spina Bifida ☐ Breathing Problems ☐ Frequent Diarrhea

☐ Irregular heartbeat ☐ Stomach / Intestine ☐ Bruise Easily ☐ Frequent headache
☐ Kidney Problems ☐ Cancer ☐ Genital Herpes ☐ Leukemia ☐ Thyroid disease ☐ Hay Fever
☐ Chemotherapy ☐ Glaucoma ☐ Liver Disease ☐ Tuberculosis ☐ Chest pain ☐ Convulsions
☐ Low blood pressure ☐ Heart attack/ Failure ☐ Lung Disease ☐ Venereal Disease

Are you allergic to the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Metal
☐ Latex ☐ Other: _____.

All the information provided is true to the best of my knowledge. If there are any changes to my health or medications I will inform Shape dental .

X _____ Date: _____.
(Patient signature/ Parent or Guardian signature)

X _____ Date: _____.
(Doctors Signature)



CONSENT FOR DENTAL TREATMENT - GENERAL

Cleaning (Prophylaxis):

Proposed treatment: involves thorough cleaning of teeth to help heal inflamed or infected gums tissue.

It involves removal of soft plaque build-up and harder calculus deposits above and below the gum line.

Benefits of treatment: healthy oral environment; also, reduction/elimination of bleeding, odor and periodontal disease.

Alternatives of treatment: referrals for periodontal (gum) surgery according to the severity of condition.

Common risks: bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint.

Consequences of not performing the treatment: discontinued or interrupted treatment could result into further inflammation and infection of gum tissue, lead to tooth decay, and deterioration of surrounding bone structure which could lead to tooth loss.

Anesthetic:

Proposed treatment: Injection of anesthetic to surrounding oral tissues.

Benefits of treatment: numbness of tissue and muscle surrounding area of treatment to eliminate pain sensation.

Alternatives to treatment: dental restorations performed with no anesthetic resulting in severe sensitivity and pain.

Common risks: allergic reaction, Irritation to nerve tissue, stiff or sore jaw joint, swelling of tissue, bruising and may cause temporary or permanent paralysis.

Consequences of not performing the treatment: severe pain and sensitivity.

Fillings:

Proposed treatment: to remove dental caries and replace with filling material to regain proper tooth anatomy.

Benefits of treatment: restore tooth structure for proper function.

Alternatives of treatment: temporary filling, crown extraction.

Common risks: allergic to filling material, tooth sensitivity, filling may come out.

Consequences of not performing the treatment: further spread of decay, requiring root canal treatment or severe destruction resulting on tooth loss.

Amalgam (Silver) VS. Composite (Tooth Color);

Amalgam advantages include: strong, can stand up to a biting force, cost effective, resistance to further decay is high risk of sensitivity is lower, long lasting.

Disadvantages include: less attractive than tooth color alternatives, placement may require removal of healthy tooth structure, corrosion may darken the appearance.

Composite advantages include: color and shade can be matched to the teeth, permits preservation of as much tooth structure as possible, frequency of repair is low.

Disadvantages include: can break or wear out quicker than silver, more expensive, may leak over time requiring replacement, can create sensitivity with cold.

Tooth Extraction:

Proposed treatment: complete removal of tooth from the mouth

Benefits of treatment: to remove symptoms and/or permit further planned treatment

Alternatives of treatment: depending on individual treatment needs; root canal treatment, periodontal therapy, crown or filling, no treatment

Common risks: as with any surgical procedure; discomfort, bleeding, swelling, possible damage to adjacent teeth and/or

soft tissue, transient numbness of the jaw

Consequences of not performing the treatment: increase in severity of pain, swelling, infection, and possible hospitalization and rare instances death.

I have read and understood the entire information on this consent form, which includes x-rays, cleaning, anesthetic, filling, root canal treatment, crown and bridge, tooth extraction and dental implants. All my questions were answered to my full understanding and satisfaction. I have discussed treatment alternatives, risk, outcomes, and costs with my dentist and have had all my questions answered before making a decision.

Further, I understand that dentistry is not an exact and that there are no guaranteed results. Unless otherwise, provided by law, I understand that i am responsible for payment of all dental fees not paid in full by any insurance or other applicable coverage. Having had adequate time to reflect upon the alternatives, I consent to the treatment, subject to changes in the treatment plan.

First Name

Last Name

Date Of Birth

Patient/Legal Guardian Signature

Date

CONSENT FOR X-RAYS AND ORAL EVALUATION

Patient Name _____

Date of Birth _____

It is your right, as a patient, to understand the risks, benefits, and alternatives of your dental treatment, and to accept or refuse treatment offered to you.

Please read this form carefully and ask about anything you do not understand.

Exam

Every patient is a unique individual thus not every patient will require the same treatment to obtain a comprehensive oral examination. Based upon your age, teeth present, and tooth position, Dr.***** will determine if radiographs (x-rays) are necessary. In general, the examination appointment also includes cleaning of the teeth and application of topical fluoride/fluoride varnish.

Treatment

If you should need any dental treatment after the dental examination has been completed, Dr.***** will review the planned treatment with you.

Please read the following information regarding dental treatment at our office.

- It is our policy that all treatment options are explained to the patients), including treatment alternatives, advantages, and disadvantages of each. Although good results are expected, it is not possible to guarantee success due to the possibility of complications.
- Risks that are occasionally associated with dental treatment procedures include: Numbness, swelling, bleeding, soreness, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reaction and infection. On rare occasions complications may arise that require hospitalization.

With my signature | authorize Shape dental contractor or employee to expose x-rays for diagnostic purposes and perform a dental exam and I acknowledge that I have reviewed the possible risks and complication associated with dental examination and x-rays.

Patient/Parent/Guardian Printed Name

Relationship to Patient

Patient/Parent/Guardian Signature

Date

Witness Printed Name

Witness Signature



Consent for Composites

Anesthetic:

Proposed treatment: injection of anesthetic to surrounding oral tissues.

Benefits of treatment: numbness of tissue and muscle surrounding area of treatment to eliminate pain sensation.

Alternatives to treatment: dental restorations performed with no anesthetic resulting in severe sensitivity and pain.

Common risks: allergic reaction, irritation to nerve tissue, stiff or sore jaw joint, swelling of tissue, bruising and may cause temporary or permanent paralysis.

Consequences of not performing the treatment: severe pain and sensitivity.

Fillings:

Proposed treatment: to remove dental caries and replace with filling material to regain proper tooth anatomy.

Benefits of treatment: restore tooth structure for proper function.

Alternatives of treatment: temporary filling, crown, extraction.

Common risks: allergic to filling material, tooth sensitivity, filling may come out.

Consequences of not performing the treatment: further spread of decay, requiring root canal treatment or severe destruction resulting in tooth loss.

Amalgam (Silver) VS. Composite (Tooth Color):

Amalgam advantages include; Strong, can stand up to biting force, cost effective, resistance to further decay is high, risk of sensitivity is lower, long lasting.

Disadvantages include; less attractive than tooth color alternatives, placement may require removal of healthy tooth structure, corrosion may darken the appearance.

I have read and understood the entire information on this consent form, which includes x-rays, cleaning, anesthetic, fillings, root canal treatment, crown and bridge, tooth extraction and dental implants. All my questions were answered to my full understanding and satisfaction. I have discussed treatment alternatives, risks, outcomes, and costs with my dentist and have had all of my questions answered before making a decision.

Further, I understand that dentistry is not an exact science and that there are no guaranteed results. Unless otherwise provided by law, understand that/am responsible for payment of all dental fees not paid in full by any insurance or other applicable coverage. Having had adequate time to reflect upon the alternatives, I consent to the treatment, subject to changes in the treatment plan.

Patient/Legal Guardian Signature

Date

Acknowledgement of Receipt of Notice of Privacy Practices and HIPPA

Non-Secure Communication Consent Form

Patient Name : _____ . DOB: _____ .

This consent form allows Shape Dental to use and disclose information about me protected under the health insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Shape Dental has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Shape Dental.

_____ I hereby authorize Shape Dental to use unsecured email and mobile Initial phone text
INT. messaging to transmit to me the following protected health information:

_____ I Information related to the schedule of appointments; and, 2) Initial information
INT related to billing and pay

_____ I hereby authorize that Shape Dental may leave messages on my voicemail to
INT confirm appointments, and/or may speak with other members of my household
and leave messages with them regarding my appointments.

_____ Email _____ Home Phone Initial
_____ Office Phone _____ Cell Phone I hereby authorize that
Shape Dental may disclose my health
information to any person(s) who accompany me to my appointment and are
present with me in the office while I meet with my dentist and staff.

_____ I hereby authorize that Shape Dental may disclose my personal Initial health
information to the person who i have listed as my emergency contact.

_____ I hereby authorize that Shape Dental may disclose my personal Initial health
information to the following person(s):

Name:	Telephone number:	Relationship:
Name:	Telephone number:	Relationship:

I understand that at any time I have the right to revoke this consent provided that I do so in writing but that Shape Dental services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Shape Dental may refuse service if I revoke this consent.

I understand that I have the right to request-now and in the future-how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Shape Dental is not required to agree to my requested restrictions, if it does agree, it is bound by agreement.

By my signature below, I affirm the above information.

Signature of Patient/Parent/Guardian_____ Date_____

Authorized Representative_____ Date:_____

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Sky Point Dental PLLC/ Shape Dental; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Signature of patient or parent/legal guardian/legally responsible person

Date

Description of relationship to patient

TO BE COMPLETED BY STAFF

Complete all applicable parts—Please refer to instructions.

Part 1. Complete if signature requested but not obtained:

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

- Patient/personal representative refused to sign form
- Other _____

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:

- Form mailed/sent to patient/personal representative on (date): - _____

Part 3. Complete if either Part 1 or Part 2 completed:

Signature of staff member

Date



Shape Dental

4881 Williams Drive, Suite-207
Georgetown, TX 78633
512-522-9922

PATIENT CANCELLATION & MISSED APPOINTMENT POLICY

_____ This policy helps us secure commitment and appointments so that we can help most each day.
INT

_____ In order to provide you with the best care possible, we ask that you make every effort to keep
INT Your scheduled appointments and arrive in a timely manner.

_____ If you need to reschedule or cancel an appointment we require a minimum of 24hr notice
INT Please call the office at 512-522-9922.

_____ Missed appointments or last-minute cancellations leave empty appointment times: as well as
INT other patients waiting to receive dental care.

_____ After 3 missed appointments. We may decide to schedule only as a "Walk-in basis"
INT

_____ After 3 subsequent dental visit, we may schedule regular appointments
INT

We realize on a rare occasion, emergencies may arise, and we will address these situations with you at the time. We thank you for working with us to ensure services are provided to you in the best possible way.

ACKNOWLEDGMENT OF CANCELLATION & NO SHOW POLICY

Your signature on this document indicates your understanding and acceptance of our policy regarding cancellation and or missed appointments

Patient Name:_____.

Patient Signature:_____.

Date: _____.