THANK YOU FOR CHOOSING US AS YOUR DENTAL PROVIDER.
WE ARE EXCITED TO WORK WITH YOU AT THE SMILE SHACK!

PLEASE TAKE A FEW MINUTES TO REVIEW AND FILL OUT THE FORMS.

VICTORIA E. SHACK, DDS
3 MEDICAL DR, STE D
PORT JEFFERSON, NY 11776
TEL: (631) 928-7500
FAX: (631) 928-7501

Patient Information

Patient Name ____ Date ______________
Last First MI (Preferred Name)

Social Security #: ______________ Birth Date: ________ Gender _____ Driver's License # ______________

Phone (Home) ______________ (Work): ______________ Ext: ________ Cell: ______________

E-Mail Address ______________________________ Would you like appt reminders by **Phone, E-Mail** or **Text**? ☐ Y ☐ N

Address ____
Street City State Zip Code

Health History

Have you ever had or been diagnosed with any of the following conditions? Please check all that apply:

☐ AIDS	☐ Excessive Bleeding	☐ Liver Disease	☐ Sinus Problems
☐ Anemia	☐ Fainting	☐ Mental Disorders	☐ Stomach Problems
☐ Arthritis	☐ Glaucoma	☐ Nervous Disorders	☐ Stroke
☐ Artificial Joints	☐ Growths	☐ Pacemaker	☐ Tuberculous (TB)
☐ Asthma	☐ Hay Fever	☐ Pregnancy	☐ Tumors
☐ Blood Disease	☐ Head Injuries	☐ Radiation Therapy	☐ Ulcers
☐ Cancer	☐ Heart Disease	☐ Respiratory Problems	
☐ Diabetes Type I or II	☐ Heart Murmur	☐ Rheumatic Fever	

Are you taking any medications (including aspirin)? ☐ Yes ☐ No

If yes, please list medications ______________________________

Do you need to be pre-medicated with antibiotics before dental treatment? ☐ Yes ☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

Have you been admitted to a hospital or needed emergency care in the past two years? ☐ Yes ☐ No

If yes, please explain ______________________________

Are you under the care of a physician now? ☐ Yes ☐ No

If yes, please explain ______________________________

Do you have any other conditions not listed here? ☐ Yes ☐ No

If yes, please explain ______________________________

Name of Primary Care Physician ______________________________ Phone ______________

To the nest of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

____ Date ______________
Signature of Patient, Parent, or Guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Friend/Family Name ______________________

☐ Dental Office ☐ Google ☐ Newspaper ☐ School ☐ Work ☐ Insurance Plan ☐ Other ______________

Spouse or Responsible Party Information (Parent/Guardian)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name ______________________________ Date ____________
Last First MI (Preferred Name)

Social Security #: ____________ Birth Date: ________ Gender _____ Driver's License # ____________

Phone (Home) ____________ (Work): ____________ Ext: ______ Cell: ____________

E-Mail Address ______________________________

Address ______________________________
Street City State Zip Code

Employment Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Employer ______________________________ Occupation ____________

Address ______________________________
Street City State Zip Code

Insurance Information

Primary Insurance Information

Name ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insurance Plan Name ______________________________

Insured Birth Date ____________ ID # ____________ Group # ____________

Insured Employer Name ______________________________

Employer's Address ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Secondary Insurance Information (if none, check here ☐)

Name ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insurance Plan Name ______________________________

Insured Birth Date ____________ ID # ____________ Group # ____________

Insured Employer Name ______________________________

Employer's Address ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in cash at the time of service.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients' insurance forms or assist in making collection from the insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months form the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to the Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time of payment thereof. I Further agree that a waiver of any breach of anytime or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

______________________________ Date ____________ Relationship to patient ____________
Signature of patient, parent or guardian

______________________________ Date ____________ Relationship to patient ____________
Signature of guarantor (if not patient)