



Patient's Name:				
If Child, Parent's Name:	Last Name	First Name	Initial	Preferred Name
Patient's Home Address:	Last Name	First Name	Initial	Preferred Name
	City		State	Zip Code
Ways to Contact You:	() -	() -	() -	() -
	Home Phone	Business Phone	Mobile Phone	Fax
	E-mail Address: _____			
	During office hours:		The best way to reach me is: _____	
	The best time to reach me is: _____			
Patient's Information:	Marital Status:	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
		Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>	Date of Birth: / /
	SS #:	- -	Driver's License #:	State:
If Full-time Student:	Name of School:		City, State:	
Employer's Name:	Occupation:			
	Business Address:		Suite No:	
	City		State	Zip Code
Spouse/Parent:				
Parent's Home Address: (If different from above)	Last Name	First Name	Initial	Preferred Name
	City		State	Zip Code
Ways to Contact Spouse/Parent:	() -	() -	() -	() -
	Home Phone	Business Phone	Mobile Phone	Fax
	E-Mail Address: _____			
	During office hours:		The best way to reach me is: _____	
	The best time to reach me is: _____			
	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth: / /		
	SS #:	- -	Driver's License #:	State:
Spouse/Parent Employer's Name:	Occupation:			
	Business Address:		Suite #:	
	City		State	Zip Code

How did you hear about us?	<input type="checkbox"/> Referred by _____	<input type="checkbox"/> Web page	<input type="checkbox"/> Welcome Letter
	<input type="checkbox"/> Chamber of Commerce	<input type="checkbox"/> Location	<input type="checkbox"/> Stonebridge Directory
	<input type="checkbox"/> McKinney Living	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other _____
In case of emergency, who should be called?	Name: _____ () -		Relationship to Patient:
Dental Insurance:	Primary Dental Coverage:		
	Employer's Name:	Group/Policy No.:	
	Employee's Name:	Date of Birth: ___/___/___	
	Employee's SS: - -	Badge No:	Date Employed: ___/___/___
	Insurance Company:		
	Insurance Claim Address:	City, State Zip:	
	Insurance Telephone No.:		
	Secondary Dental Coverage:		
	Employer's Name:	Group/Policy No.:	
	Employee's Name:	Date of Birth: ___/___/___	
	Employee's SS: - -	Badge No:	Date Employed: ___/___/___
	Insurance Company:		
	Insurance Telephone No.:		
Who is responsible for this account?	Name:		Relationship to the patient:
Assignment and Release	I, the undersigned, have insurance with _____ (Name of Insurance Company(ies)) and assign directly to Dr. Timothy P. Shannon, DDS all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.		
	Date		Signature
Minor/Child Consent	I, being the parent or guardian of _____ (Name of Minor/Child) do hereby request and authorize the dental staff of Dr. Timothy P. Shannon, DDS to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.		
	Date		Signature
Financial Agreement	I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges not covered by insurance.		
	Date		Signature

PATIENT HEALTH HISTORY

1. How do you feel about getting and keeping a healthy mouth? _____
2. How do you feel about the appearance of your teeth? _____
3. Are you happy with your smile? If not, what would you like to change about it? _____
4. Are you having any dental problems at this time? Yes No
5. Are you having pain or discomfort at this time? Yes No
6. Do your gums bleed at any time? Yes No
7. Do you feel nervous or anxious about having dental treatment? Yes No
8. Have you ever had a bad experience in the dental office? Yes No
9. Have you ever been diagnosed with periodontal gum disease? Yes No
10. Have you ever been treated with periodontal therapy? Yes No
11. Have you been under the care of a medical doctor during the past 2 years? Yes No

If yes, for what reason? _____

Your Physician's Name: _____

Office Address: _____ Telephone No.: _____

Date of Last Complete Medical Physical: _____

12. Have you been hospitalized during the past 2 years? Yes No

If yes, for what reason? _____

13. Have you taken any medicine or drugs during the past two years? Yes No

Are you now taking any medicine or drugs (including non-prescription)? Yes No

If so, please provide a complete list of medications, dosage, and how taken: (use additional paper, if necessary)

Medication	Dosage	Daily Frequency

14. Are you allergic to (i.e. itching, rash, swelling of hands/feet/or eyes) or have you reacted adversely (made sick) to any of the following items? Yes No

If yes, please circle:

Aspirin	Codeine	Darvon	Demerol	Percodan
Vicodin	Lortab	Penicillin	Erythromycin	Tetracycline
Sleeping Pills	Local Anesthetic	Nitrous Oxide Gas	Latex	

Any other medications or substances? If yes, please list: _____

Patient Health History, cont.

15. Have you ever had excessive or uncontrollable bleeding that required special treatment? Yes No
16. When you climb stairs or take a walk, do you ever have to stop because of pain in your chest, of shortness of breath, or because it makes you very tired? Yes No
17. Do your ankles swell during the day? Yes No
18. Do you use more than two pillows to sleep? Yes No
19. Do you ever wake up from sleep short of breath? Yes No
20. Do you use any tobacco products? Yes No
21. Have you lost or gained more than ten pounds in the past year? Yes No
22. Are you on a special diet? Yes No
23. Do you experience frequent thirst or frequent need to urinate? Yes No
24. Have you ever been diagnosed/treated for a tumor or cancer? Yes No

If yes, please explain: _____

25. Circle any of the following conditions which you have had or currently have:

- | | | | |
|------------------------------|--|-------------------------------|-----------------------------|
| Allergies or Hives | Diabetes | Heart (Mitral) Valve Prolapse | Rheumatic Fever |
| Anemia | Drug Addiction/Alcoholism | Heart Murmur | Rheumatism |
| Angina Pectoris (chest pain) | Eating Disorder | Heart Pacemaker | Scarlet Fever |
| Arthritis | Emphysema | Heart Surgery | Sickle Cell Disease |
| Artificial Heart Valve | Epilepsy or Seizures | Hemophilia | Shortness of Breath |
| Artificial Joint of Any Type | Fainting or Dizzy Spells | Hepatitis (any type) | Stroke |
| Asthma | Family History of Cardiovascular Disease | High Blood Pressure | Thyroid Disease |
| Blood Transfusion | Fibromyalgia | HIV Positive (AIDS) | Tuberculosis (TB) |
| Bruise Easily | Genital Herpes | Kidney Disease | Ulcers |
| Cancer or Tumors | Glaucoma | Liver Disease | Venereal Disease (any type) |
| Chemotherapy | Hay Fever | Nervousness | Yellow Jaundice |
| Cold Sores or Fever Blisters | Heart Disease or Attack | Pain in Jaw Joints | X-ray or Cobalt Treatment |
| Congenital Heart Lesions | Heart Failure | Persistent Coughs | |
| Cortison Medication | | Psychiatric Treatment | |

For women only: Currently pregnant Yes No If yes, expected due date: _____

Currently taking Birth Control Medication Yes No

26. Do you have, or have you had, any disease, condition, or problem not listed? Yes No

If yes, please explain: _____

I confirm that the above information is accurate, true, and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Name: _____

Date: _____

Patient Signature(or Parent/Legal Guardian if Minor): _____



Consent to Perform Dentistry

I, _____, hereby consent to and authorize Dr. Timothy P. Shannon, DDS, and/or his dental auxiliaries and assigns, to provide and perform any or all of the following dental treatment procedures, including oral surgery, in conjunction with the use of any necessary or advisable radiographs and other diagnostic aids as he deems useful:

1. Preventive periodontal care and maintenance, including topical fluoride application when beneficial;
 2. Application of unfilled resin material, known as "sealants," to the occlusal (bite) grooves of the posterior teeth as a preventive treatment against tooth decay;
 3. Treatment of the soft tissues (gums) in the presence of acute or chronic periodontal disease and/or injury;
 4. Treatment of diseased or injured hard tissues, including teeth with suitable dental restorations (fillings or crowns), root canal therapy, or limited oral surgery (including tooth extraction) as circumstances require;
 5. Replacement of missing teeth with dental prostheses using fixed and/or removable appliances (bridgework; partial or full denture; implant restoration);
 6. Non-surgical evaluation/treatment of the temporomandibular joint, myofacial pain, and/or occlusal dysfunction, including the use of bite splint therapy, and limited or full mouth adjustment/equilibration;
 7. Treatment of malposed (crooked), chipped, or discolored teeth, and/or oral development and growth problems;
 8. Use of conscious sedation techniques (nitrous oxide analgesia; oral medication) to control and manage anxiety or disruptive behavior.
- I understand and accept that there are inherent risks associated with any dental treatment and hereby acknowledge that these risks have/will be explained to me, that I will have the opportunity to ask questions regarding the recommended treatment and its associated risk, and I am satisfied with the explanation given.
 - I understand that there are potential risks and complications associated with the use of local anesthesia, nitrous oxide analgesia, and oral sedative medications, including allergic reaction (itching, tissue rash, breathing difficulty), pain, swelling, bleeding, bruising, hematoma (blood bruise at or near injection site), nausea, vomiting, tingling and/or numbness in area of anesthetized tissues subsequent to treatment for an indeterminate length of time, fainting, and biting of the soft tissues while numb resulting in ulceration/inflammation. I also understand that in rare circumstances the risk may include severe respiratory and cardiovascular complications, including total collapse (stopping of breathing and heart function; oxygen deficiency to the brain leading to possible coma or death). I acknowledge that I have been informed of such risks.
 - I understand that when using the nose piece for nitrous oxide administration, it may leave an indentation or ring around the nose which disappears shortly after the use of the nose piece is discontinued.
 - I understand that during the course of treatment it may be necessary to alter and/or amend the prescribed treatment due to unforeseen circumstances that could not be anticipated earlier. I request and authorize the performance of any additional treatment procedures that are deemed necessary according to the professional judgment of the dentist.
 - I understand and am advised that the overall success of any recommended dental treatment requires that the patient (and parents in the case of a minor) adhere to any and all post-treatment care instructions given by the dentist and/or the dental auxiliaries. In addition, the maintenance of regular re-care visits as scheduled will directly affect the long-term success of any treatment that is given.
 - I understand and authorize the dentist, his dental auxiliaries, and assigns to use any radiographs, photographs, and other diagnostic materials/treatment records for the purpose of teaching, research, and scientific publication.
 - In conclusion, I hereby state that I have read and understand this consent, that all questions with regard to dental procedures have been/will be answered to my satisfaction, and that I may require additional information whenever I deem it necessary to make an informed decision concerning my dental care. I further acknowledge and agree that this "consent to perform dentistry" will remain in effect until such time that I choose to terminate it.

Date: _____
 Patient Name: _____
 Name of Parent or Guardian: _____
 Relationship to Patient: _____
 Signature: _____

Witness: _____