

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_  
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

**Patient Information**

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

**Section 2**

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

**Section 3**

Parent/Guardian: \_\_\_\_\_

Fax #: \_\_\_\_\_

Referred By: \_\_\_\_\_

Preferred Nickname: \_\_\_\_\_

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

**MEDICAL HISTORY**

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_  
Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_  
Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_  
Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_  
Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_  
Are you on a special diet?  Yes  No \_\_\_\_\_  
Do you use tobacco?  Yes  No \_\_\_\_\_  
Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you  
Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  
 Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Breathing Problem <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No	

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

Edward I. Shapiro, D.D.S  
1315 East Blvd. Suite 260  
Charlotte, NC 28203  
704.632.9922

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Please circle yes or no for each behavior/habit question.

- |                      |        |
|----------------------|--------|
| 1. Grind your teeth  | Yes/No |
| 2. Bite cheek        | Yes/No |
| 3. Mouth Breather    | Yes/No |
| 4. Bulimia/Anorexia  | Yes/No |
| 5. Cigar/Cigarette   | Yes/No |
| 6. Pipe              | Yes/No |
| 7. Bite Nails        | Yes/No |
| 8. Smokeless Tobacco | Yes/No |
| 9. Headaches         | Yes/No |

Are your teeth sensitive to:

- |                      |        |
|----------------------|--------|
| 1. Hot or Cold       | Yes/No |
| 2. Biting or Chewing | Yes/No |
| 3. Sweets            | Yes/No |

Have you ever had:

- |  |        |
|--|--------|
| 1. Orthodontic treatment                   | Yes/No |
| 2. A bite appliance or guard               | Yes/No |
| 3. Periodontal surgery                     | Yes/No |
| 4. Oral surgery                            | Yes/No |
| 5. Serious injury to the mouth<br>or head. | Yes/No |

General Dental Questions:

- |                                  |        |
|----------------------------------|--------|
| 1. Are you happy with your smile | Yes/No |
| If no, why: _____                |        |
| 2. How often do you brush?       | _____  |
| 3. How often do you floss?       | _____  |
| 4. Oral Cancer?                  | _____  |
| 5. Mouthwash                     | _____  |
| 6. Toothpaste                    | _____  |



Dear Valued Patient:

Thank you for selecting our office for your dental needs. Our goal is to provide you with prompt, courteous, quality dental care.

**Payment in full or your estimated portion is due at the time services are rendered.** We accept cash, check and for your convenience, Visa, MasterCard, American Express & Discover. We will be happy to process your dental claim as long as you provide your current dental insurance card or form and provide accurate information for filing.

In most instances, we will accept assignment of insurance benefits. However, you must understand that we participate with many dental insurance carriers, and for that reason, we do need to emphasize the following:

1. Your insurance policy is a contract between you, your employer and the insurance company. **We are not a party to that contract.** Our relationship is with you, not your insurance company.
2. **All Charges are your responsibility whether your insurance company pays or not.** Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover.
3. **Fee for non-covered benefits, along with unpaid deductibles and co-payments are due at the time services are rendered.**
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help expedite the process.
5. If the insurance company does not pay in full within 60 days, we require you to pay the balance due.
6. Finance charges on unpaid balances will accrue at the annual percentage rate of 18% or 1.5% a month for balance over 90 days.

There will be a charge of \$25.00 fee for all returned checks regardless of reason.

**There will be a charge of no less than \$50.00 but not to exceed \$150.00 for all appointments cancelled without a 24 hour notice (during office hours) and for all appointments that are missed without notice to our practice.**

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems so that we can assist you in the management of your account. If for any reason you have a problem or question regarding the treatment that was rendered to you, please feel free to contact our office.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

By my signature, I indicate that I have read this policy, understand its content and agree to its provisions

Our office hours are: Monday through Thursday 7:30 until 5:00. WE ARE CLOSED FOR ALL MAJOR HOLIDAYS.



### Dental Insurance Policy

Our office needs to clarify terms and conditions regarding your dental insurance. Insurance companies reimburse you an amount they figure is commensurate with average quality dentistry.

Insurance companies' fee schedules are on par with average fees for dental services based on 10 years ago. Dr. Shapiro strives to hire very knowledgeable and experienced staff. Dr. Shapiro and staff enroll routinely in continuing education classes to maintain and improve our skills and knowledge to offer our patients the best care available.

The quality of materials we use are top of the line; they are the best and most accurate available. The labs we use to create highly esthetic, functional and long lasting dental restorations, use master craftsmen who are highly skilled and artistic in their abilities.

The fees we charge for restorative and cosmetic procedures may be in excess of your insurance companies' fee table and allowances. You will be responsible for the difference. We will be happy to file your insurance for dental services provided. Please remember your insurance company dictates only your coverage, not your necessary and recommended treatment. Insurance companies will routinely give alternate benefits for certain procedures. This is a means to save the insurance company money and provide minimal dental treatment, denying you the best treatment available today.

We will not let insurance companies dictate our treatment for you. A denial of service only means the insurance company does not cover the type of treatment you need. We value you as our patient and will continue to offer the highest levels of dentistry required to restore your teeth and mouth to a state of ideal form and function.

Name \_\_\_\_\_

Date \_\_\_\_\_



STATE OF NORTH CAROLINA  
COUNTY OF MECKLENBURG

AGREEMENT OF  
CONSENT AND RELEASE

THIS AGREEMENT OF CONSENT AND RELEASE is made and entered into as of  
The \_\_\_\_\_ day of \_\_\_\_\_, 2007 by and between \_\_\_\_\_.  
(Hereinafter referred to as the 'patient'), and Dr. Shapiro, (hereafter referred to as the 'Dentist')

STATEMENT OF PURPOSE:

Dentist is engaged in the practice of conventional, esthetic and cosmetic dentistry. Patient has entered into a patient-dentist relationship with Dentist for performance of certain dental procedures.

(The Services). Dentist uses photographs of patients to record the effects of treatment before, during and after the rendition of the services. Dentist uses such photographs not only to demonstrate to the patient receiving the services, but also to other patients certain dental techniques and the results that have been achieved in connection with such services. Photographs taken of patient may reveal the identity of the patient and in certain instances may display all or part of patient's teeth, smile and face. In consideration for the Services, Patient has agreed to allow photographs to be taken of Patient by Dentist and team before, during and after the rendition of the Services for the purposes described above.

In consideration of the Services to be rendered, the parties hereto agree as follows:

Patient's Consent and Release. Patient grants to Dentist and Dentists' Team Members the right to photograph Patient treatment before, during and after the rendition of the Services.

The patient acknowledges the photographs may be used to illustrate results of specific procedures in types of media including but not limited to our web site, the Internet, newspapers, magazines, phonebooks, television and professional publications (dental magazines and journals.)

Patient grants Dentist the right to duplication of such photographs to existing patients or Dentist as well as prospective patients of Dentist, whether displays take place at the office of Dentist's practice or elsewhere. Patient further acknowledges that Patient has no interest whatsoever in any professional fees derived by Doctor from the subsequent performance of professional services for the person or persons who view such photographs of Patient. Patient does not expect compensation, financial or otherwise, for the use of these photographs.

We are very proud of the work we have done and only use our own patients in our marketing and advertising. All of the portraits in our office, on our web site [www.shapirosmiles.com](http://www.shapirosmiles.com), and in our ads are our own patients and photography

Patient: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

# Edward I. Shapiro, DDS-PLLC

## Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have received a copy of the Notice of Privacy Practices for the above named practice.

\_\_\_\_\_  
Signature Date

Email address: \_\_\_\_\_

### For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

\_\_\_\_\_

- Other: \_\_\_\_\_  
\_\_\_\_\_

Prepared By: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

AUTHORIZATION FOR RELEASE OF INFORMATION  
TO FAMILY AND/OR FRIENDS

Name of Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Edward I. Shapiro, DDS and staff is authorized to release protected health/dental information about the above named patient to the entities named below.

ENTITY TO RECEIVE INFORMATION-INITIAL EACH THAT IS SUBJECT TO THIS  
AUTHORIZATION

\_\_\_\_ Leave any/all information on Voice Mail/Answering Machine  
\_\_\_\_ Give information to following Persons: \_\_\_\_\_  
\_\_\_\_ Give information to Spouse: \_\_\_\_\_  
\_\_\_\_ Give information to Parents: \_\_\_\_\_

DESCRIPTION OF INFORMATION TO BE RELEASED:

\_\_\_\_ Financial Information  
\_\_\_\_ Family Billing Information  
\_\_\_\_ Medical/Dental information  
\_\_\_\_ Results of x-rays/test  
Other information: \_\_\_\_\_

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health/dental information to be disclosed as described in this document by sending written notification to Edward I. Shapiro, DDS. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of the authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

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Signature of Patient or Personal Representative    Date:

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