



SHORE DENTAL CARE

Cosmetic & Restorative Dentistry

Stefanie Shore, DDS

Welcome!

Thank you for selecting our office for your dental care!

Your first visit will include a comprehensive oral evaluation and diagnostic digital photos. We will review your medical and dental histories and take necessary X-rays. We make every effort to use X-rays taken by your previous dentist if they are recent and of good quality. If you wish to use your previous X-rays, please be sure we have them by the time of your initial appointment. We will be happy to call your previous office to request them if you provide the name and phone number.

Immediately after your examination, or at a separate consultation appointment, Dr. Shore will discuss with you your oral health needs and treatment options. Your understanding of these options and participation in decisions about your treatment will form the foundation for good oral health. We encourage your questions! Children will usually receive a cleaning and fluoride treatment along with their initial examination. However, most often our adult patients need to return for cleanings due to the tremendous variability in periodontal (gum) health.

Please complete the enclosed forms and bring them with you to your first appointment. If you have a dental insurance benefit plan that helps you with the cost of some of your dentistry, bring in your card and brochure so that we can help you maximize your dental benefits. For your first visit, plan to spend approximately one hour with us. Due to the length of time we have reserved for you, we need at least two business days' notice if you are unable to keep your appointment.

Your comfort during visits is very important to us. Please feel free to let us know if we can do anything to make your visit more pleasant. Our practice philosophy is centered around keeping your teeth and gums healthy for a lifetime. We hope you are pleased with our office and will feel confident in referring your friends and family.

If you have a dental emergency, call us right away. We save time every day to help patients with urgent problems. For after-hours emergency care, please call the office and follow the instructions given on our voicemail system.

We look forward to meeting you!

Stefanie Shore, DDS, and Staff

Stefanie Shore, DDS
5723 Marconi Avenue
Carmichael, CA 95608
(916) 966-4341



SHORE DENTAL CARE
Cosmetic & Restorative Dentistry

This information is confidential and is for Dr. Shore's records only. Please take a few moments to answer all questions completely and accurately. There are 4 parts to this form. Thank you.

PATIENT INFORMATION

Patient Name: (First) _____ (Initial) _____ (Last) _____
Home Address: (Street) _____ (City) _____ (ZIP) _____
Employed By: _____ Occupation: _____
Work Address: (Street) _____ (City) _____ (ZIP) _____
Birthdate: _____ Home Phone: () _____ Work Phone: () _____
E-mail: _____ Cell Phone: () _____
Soc. Sec #: _____
If full time student, name of school: _____
Who may we thank for referring you to our office? _____
Insurance: (Company) _____ (Group#) _____ (ID#) _____

SPOUSE/PARTNER INFORMATION

Spouse's Name: (First) _____ (Initial) _____ (Last) _____
Employed By: _____ Occupation: _____
Work Address: (Street) _____ (City) _____ (ZIP) _____
Work Phone: () _____ Cell Phone: () _____
Birthdate: _____ Soc. Sec #: _____
Insurance: (Company) _____ (Group#) _____ (ID#) _____

PERSON FINANCIALLY RESPONSIBLE

- Check here if same as "patient" above
- Check here if same as "spouse" above

Name: (First) _____ (Initial) _____ (Last) _____
Home Address: (Street) _____ (City) _____ (ZIP) _____
Employed By: _____
Work Address: (Street) _____ (City) _____ (ZIP) _____
Work Phone: () _____ Cell Phone: () _____
Birthdate: _____ Home Phone: () _____ Home Fax: () _____
Soc. Sec #: _____

CONSENT FOR TREATMENT OF A MINOR

I, (parent/guardian name) _____, being the parent, guardian, or other person entitled to legal custody of (name of minor) _____, a minor child, do hereby authorize and consent to any x-rays, examination, anesthetic, or dental treatment to be rendered to said minor under the general or direct supervision of Stefanie Shore, DDS, as Dr. Shore deems necessary. This authorization will remain in effect unless Dr. Shore is notified by the parent or guardian.

Parent/guardian signature _____ Date _____

Stefanie Shore, DDS
5723 Marconi Avenue
Carmichael, CA 95608
(916) 966-4341



Insurance Information

Please bring your insurance I.D. card with you to your first appointment so that we may assist you in billing your insurance company. Without this information, your insurance company will not reimburse you for the costs of your dental visits. If your insurance coverage changes in the future, please bring your new insurance I.D. card. If you have dual insurance coverage, please bring your secondary insurance information as well.

As a courtesy, we will prepare and send your insurance claims for you. In order to do this, we need you to read and sign the following two (2) “Signatures On File.” These two (2) “Signatures on File” are standards taken from the American Dental Association’s Unclaim Dental Form (J504) and are accepted by all major insurance companies. We will keep your “Signatures On File” until you direct us not to do so.

Signature On File #1

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize the release of any information relating to this claim.

Signed (Patient or Guardian) _____ Date: _____

Signature On File #2

This must be signed by the EMPLOYEE or SUBSCRIBER who actually has the dental insurance policy. This is not necessarily the patient.

I hereby authorize payment of the dental benefits otherwise payable to me directly to my treating dentist, Stefanie Shore, DDS.

Signed (Employee/Subscriber) _____ Date: _____

MEDICAL HISTORY

Name: _____ Date of Birth: _____

1. Have you seen a medical doctor or been a patient in the hospital within the past two years? Yes No
If yes, for what problem? _____

2. Date of last complete physical examination: _____ Kaiser Number: _____

3. Medical Doctor Name: _____ Specialty: _____
Name: _____ Specialty: _____

4. Do you have now, or have you had in the past?:

	YES	NO		YES	NO		YES	NO
HEART ATTACK, DATE _____			ASTHMA			NEUROMUSCULAR DISEASE		
HEART DISEASE OR FAILURE			TUBERCULOSIS (TB) / +SKIN TEST			FAINTING OR DIZZY SPELLS		
ANGINA PECTORIS (CHEST PAIN)			ALLERGIES OR HIVES			PSYCHIATRIC TREATMENT		
CONGENITAL HEART PROBLEM			SINUS TROUBLE			CANCER OR TUMOR		
HEART OR ORGAN TRANSPLANT			DIABETES / HIGH BLOOD SUGAR			RADIATION OR CHEMOTHERAPY		
ENDOCARDITIS			EPILEPSY OR SEIZURES			GLAUCOMA		
BYPASS SURGERY / STENT			THYROID PROBLEMS			ACID REFLUX / HEARTBURN / GERD		
HEART PACEMAKER / DEFIBRILLATOR			PINS / IMPLANTS/JOINT REPLACEMENT			ULCER (STOMACH OR INTESTINAL)		
ARTIFICIAL HEART VALVE			CORTISONE MEDICATION/PREDNISONE			AUTOIMMUNE DISEASE		
HIGH BLOOD PRESSURE			ARTHRITIS			AIDS, ARC OR HIV ANTIBODY +		
ANEMIA / OTHER BLOOD DISORDER			BACK OR NECK PAIN			KIDNEY / BLADDER TROUBLE		
EXCESSIVE BLEEDING			HERPES / COLD SORES / FEVER BLISTERS			FOSAMAX / ACTONEL / BONIVA / ZOMETA		
STROKE, DATE _____			HEPATITIS / LIVER DISEASE			OTHER BIPHOSPHONATES		
EMPHYSEMA			YELLOW JAUNDICE			OSTEOPOROSIS / OSTEOPENIA		
SHORTNESS OF BREATH			DRUG / ALCOHOL ADDICTION			SURGERY		

5. Are you taking any medicines, drugs, or pills of any kind? Yes No Please list:

6. Are you allergic to any drugs, medicines, or substances? Yes No

Name of Substance: _____ Reaction: _____

7. Do you use tobacco products? Smoke Smokeless Vape How Much?: _____

8. Do you use marijuana products? Smoke Vape How Much?: _____

9. Do you have a disease, condition, or problem not listed above? _____

10: Women: Are you pregnant? Do you anticipate becoming pregnant? Do you take birth control pills?

Yes No

Yes No

Yes No

I have answered the above questions completely and accurately. I will inform my dentist of any change in my health or medicine at my next appointment.

Signature of Patient, Parent or Guardian

Date

Reviewed By

Doctor Comments:

Stefanie Shore, DDS
 5723 Marconi Avenue
 Carmichael, CA 95608
 (916) 966-4341



DENTAL HISTORY

NAME:	DATE:
Last Dental Exam:	Last Dental X-Ray:
Last Dental Treatment:	
Last Dental Cleaning:	
What is your Immediate Dental Concern?	

PLEASE CHECK ALL ITEMS WHICH APPLY:

	YES	DOCTOR'S NOTES
Unhappy with the appearance of your teeth		
Unpleasant dental experiences/dental fears		
Preference for no anesthetic		
Problems with effectiveness of Local Anesthetic		
Orthodontic treatment: Age:		
Periodontal (Gum) surgery: Date:		
Deep Cleaning/Root Planing: Date:		
Bleeding gums		
Tooth/Teeth sensitive to temperature		
Tooth/Teeth sensitive to biting		
Teeth/Gums sensitive to instruments		
Difficulty eating some or all foods		
Bad breath/Unpleasant taste in your mouth		
Jaw problems (TMJ)		
Jaw has locked open or closed		
Clench or grind your teeth		
Pain/Stiffness in the jaw or neck		
Problems with dentures or partials		
Sore or lump in mouth for more than 2 weeks		
Diagnosed with Sleep Apnea		
Snoring		
Not feeling rested after 7-8 hours of sleep		

Reasons for lost teeth (circle): DECAY GUM DISEASE KNOCKED OUT WISDOM TEETH ORTHODONTICS

Is there anything we can do to make your visit more pleasant?

Other information about your dental history or needs?

In the event that you need dental treatment, is there another person (e.g. spouse, parent, etc.) who is involved in decisions regarding your healthcare and/or your financial decisions? Yes No

If yes, please give their name and relationship to you: _____

Doctor Notes:

Stefanie Shore, DDS
5723 Marconi Avenue
Carmichael, CA 95608
(916) 966-4341



SHORE DENTAL CARE
Cosmetic & Restorative Dentistry

PATIENT'S NAME: _____

FOR ALL PATIENTS:

1. I consent to the dental practice using my cell phone number to (choose one or both)
 call or text regarding appointments and to call regarding treatment, insurance and
my account. I understand that I can withdraw my consent at any time.

My cell phone number is: (____) _____

Signature: _____ Date: _____

2. I consent to receiving from the dental practice email communications regarding
treatment, insurance, my account and special promotions. I understand that I can
withdraw my consent at any time.

My email address is: _____

Signature: _____ Date: _____

3. I acknowledge that I have been offered a copy of the Dental Materials Fact Sheet and
the office's Notice of Privacy Practice.

Signature: _____ Date: _____

4. I understand that I may be charged a 1.5% per month or 18% per year finance charge
if my balance goes beyond 90 days.

Signature: _____ Date: _____

5. I understand that I may be charged \$25.00 per half hour of scheduled time if I miss an
appointment or cancel without 2 business days notice. Also, I understand insurance
will not cover the cost of failed appointments.

Signature: _____ Date: _____

6. I understand that photographs may be taken as a record of my care, and may be used
for educational purposes in lectures, demonstrations to other patients, and marketing
efforts to include websites, publications and professional publications.

Signature: _____ Date: _____