Shannon M Coen DMD
16080 N. 59th Avenue, Suite A
Glendale, AZ 85306
602-978-1100

Patient Information Update

Patient's Name:_____Date of Birth:_____

If Minor, Parent/Guardian Name:_____

Contact Information: *Please update this information for our office to be able to communicate with you*

Address:_____

Cell Phone:_____Other Phone:_____

E-mail:_____

Please Circle, how do you want us to contact you? *Phone Call* *E-mail* *Text*

Contact Person in Case of Emergency:_____

Contact Phone Number:_____

Dental Insurance Update:

Do you have dental insurance benefits: *Yes or No*

Has your dental insurance benefit changed since your last visit: *Yes or No*

HIPAA

I have read and understand the patient privacy notice and am aware I may request a printed copy for myself. If I have any questions I have asked, and they have been answered to my satisfaction.

I authorize disclosure of my protected health information to specific individual(s) listed below:

_____

I give permission to Dr. Coen to do any necessary examinations and dental radiographs as needed.

In the event that Dr. Shannon Coen agrees to file insurance claims for myself of my family, I authorize the release of dental information necessary to process that claim and request that payment of benefits be made to Dr. Shannon Coen. I further agree to pay an amount not covered by my insurance company.

Signature:_____**Date**:_____

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Medical History:

Health History: *Your health is important to us, so we want to update your health information.*

Please fill out this section completely.

Allergies: *Do you have any of the following Drug Allergies?*

Penicillin	Yes	No	
Other Antibiotics:	Yes	No	Please List:
Latex	Yes	No	
Codeine	Yes	No	
Other Pain Medications	Yes	No	Please List:
Sulfa	Yes	No	
Other Drug Allergies	Yes	No	Please List:

***Medical History*:** *Please use the back side of this form if you need more space for your health history*

High Blood Pressure	Yes	No	Cancer	Yes	No
Cholesterol Issue	Yes	No	*Type, Year diagnosed, Chemo/Rad*		
Heart Murmur	Yes	No	Breast Cancer	Yes	No
Heart Pacemaker	Yes	No	Prostate Cancer (Men Only)	Yes	No
Stroke	Yes	No	HIV or AIDS	Yes	No
Total Joint Replacement	Yes	No	Autoimmune Disorder	Yes	No
Which one(s), Year done:			Hepatitis B or C	Yes	No
Diabetes	Yes	No	Epilepsy or Seizures	Yes	No
Last A1c			Psychiatric/Psychological Care	Yes	No
Thyroid Problems	Yes	No	Anxiety	Yes	No
Asthma or lung disease	Yes	No	Depression	Yes	No
Seasonal Allergies	Yes	No	Osteoporosis/Bisphosphonates	Yes	No
Sinus Troubles	Yes	No	Use Tobacco	Yes	No
GERD or Acid Reflux	Yes	No	Use Marijuana	Yes	No
Liver Disease	Yes	No	Use Vape	Yes	No
Kidney Disease	Yes	No	Pregnant (Women Only)	Yes	No

Other Medical Conditions (Please List): _____

_____

Medications (Please List or Provide us with a List we can Scan):

_____

_____

_____

Patient Signature: _____ **Date**: _____

Dentist's Signature: _____ **Date**: _____

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Financial Arrangements

Please review the Financial Policies for our office:

- Payment for services rendered is due at the time of service.
- We accept Cash, Checks, Debit Cards, Credit Cards, HSA/FSA Cards, and CARE Credit.
- A $50 fee will be charged for any returned Checks, and you will not be able to pay with a check again at our office.
- We have limited cash in our office so if we do not have enough to make change for you then it will be mailed to you, given to you at your next appointment, or can be held on your account as a credit.
- We only offer office financing for any case requiring lab work/multiple visits and for Invisalign treatment.
- Forty-eight (48) hours' notice is needed for cancellation or rescheduling of a dental appointment at our office. We reserve the scheduled time especially for you.
    - If you do not give Forty-eight (48) notice for any **Saturday** appointment you will not be scheduled again on a Saturday.
    - If you do not give Forty-eight (48) hour notice for **two appointments,** we reserve the right to charge you a $35 Appt Fee, reserve the right to see you on a same day basis only and will not pre-schedule any appointment including for your six-month cleanings.
    - The Appt Fee will need to be paid to schedule an appointment time at our office for you but if you cannot pay the Appt Fee then you can be seen on a same day basis. After you make your Appt Fee if you make the following appointment your Appt Fee will stay on your account as a credit. If you miss another appointment, you forfeit your Appt Fee.
    - If you miss a treatment appointment you will be asked to pre-pay your portion of the treatment to reschedule and hold an appointment time.

Dental Insurance

- We process insurance claims as a courtesy. You are ultimately responsible for knowing your insurance coverage and benefits. You are responsible for what your dental insurance does not cover or any balance after your insurance has been billed.
- We do our best to verify your coverage with your insurance. As the holder of the dental insurance plan your plan can give you more information when contacted as well as a handbook with a complete breakdown for costs/benefits for your specific plan.
- Treatment plans are only an estimate of what your insurance may pay. If you truly want to know your exact cost for the treatment, we will need to authorize your treatment with your insurance company prior to your treatment being done in our office. You will be billed for any additional costs after your insurance company pays for services rendered.
- Dual Dental Insurance Coverage: We do our best to verify your coverage by both insurances but often will not have a complete accurate out of pocket cost until both insurances have paid.

I (We) the undersigned, hereby agree to pay all amounts and charges incurred by myself and that of a member of my family for services rendered by Dr. Shannon Coen according to the financial policies established.

If Dr. Shannon Coen agrees to file insurance claims for myself or for my family, I authorize the release of dental information necessary to process that claim and request that payment of benefits be made to Dr. Shannon Coen. I further agree to pay an amount not covered by my insurance company.

Signature:_____**Date**:_____