HEALTH HISTORY UPDATE

Patient Name: ____________________

Date: ________________________

Email Address: ___________________

Health Changes: _____________________

____

____

Current Medications: _______________________

____

____

Insurance Changes:____________________

Cell Phone: _______________________

Physician's Name: _____________________

Physician's Phone # _____________________

Total Joint Replacement? (hip, knee, etc) _________

Last Physical Exam: _______________________

Allergies: __________________________________

Patient's Signature: __________________________

HIPAA & Office Policy Questionnaire

List names and dates of birth for all family members:

Name	Date of Birth	Name	Date of Birth
(Patient/Guardian)			

Sharing Medical Information
We will presume that you will allow us to share medical information with the following individuals unless you specify otherwise. Please place a check mark next to all of the following with whom you **DO NOT** wish us to share health information about you and your family.
If you do not allow us to share information with school, camp or daycare, please be advised that we are legally not allowed to fill out school, camp or daycare forms.

__Mother of Child
__Father of Child
__Step-Mother of Child
__Step-Father of Child
__Daycare
__School
__Insurance Co.
__Pharmacies
__Maternal Grandmother
__Maternal Grandfather
__Paternal Grandmother
__Paternal Grandfather
__Camp
__Other

Notice of Office Policies

- Our office gladly submits insurance claims on your behalf. Responsibility for the account remains that of the patient. A grace period of 60 days will be given for insurance purposes. If an unpaid insurance balance remains, the balance will then be due from the patient. The patient will receive reimbursement from the insurance carrier,
- Payment plans are available.
- An 18% monthly finance charge applies to any account over 90 days.
- A 24-hour notice for cancellation is greatly appreciated. Any cancellations received within 24 hours of the scheduled appointment will be subject to a **$75 cancellation fee**.
- Patients need to be aware of the terms of their dental insurance policy.

I acknowledge that on behalf of myself, or that of the above named children, I have received a copy of the **Notice of Privacy Practices and Office Policies** for Dr. Megan Shiga.

Print Name Signature Date

Megan A. Shiga, DDS, LLC

DENTAL INSURANCE AND FINANCIAL ARRANGEMENTS

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.

If you have dental insurance, we will work hard to help you receive your maximum allowable benefit. In order to achieve this goal, we need you to take the necessary steps to understanding your insurance plan. With there being so many different providers and plans, it is impossible for us to know all of our patients' benefits. It is very important for you as a dental insurance policy holder to be aware of the plan benefits, deductible and exclusions. Plan benefits can be obtained by calling your dental insurance company or logging on to their website (if available). We will gladly discuss your proposed treatment and answer any questions that you may have relating to your insurance. You, however, must be aware that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Most insurance companies have a yearly deductible that is your responsibility to pay.
3. Most insurance companies only pay a percentage of the cost (such as 50% or 80%) and you will be responsible for the remainder.
4. Not all services are a covered benefit in all contracts. It is important for you to contact your insurance provider and ask if there are any clauses or waiting periods.
5. As a courtesy to you, our office will submit claims to your insurance provider. If for any reason the claims go unpaid, you will be responsible for all charges.

If you have any questions regarding this information or any uncertainty about your insurance coverage, please don't hesitate to ask us. We are here to help you in any way we can.

I, ____________________, AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES ON MY ACCOUNT.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

SIGNATURE ________________________ DATE ________________

525 East Washington Street Chagrin Falls, OH 44022
drmeganshiga@yahoo.com   440-247-9220
www.chagrindentist.com