Paulomi R. Shah, D.D.S., M.S.D.

663 South 9th St.
Griffin, GA 30224
pshah@shahendo.com
Ph: (678) 572-8011
Fax: (770) 227-8078

Dear New Patient,

Welcome to our practice! Thank you for allowing us to serve your endodontic needs. The following information is provided to ensure a smooth transition into our practice. Please complete the enclosed forms and bring them with you to your first appointment, as it will help expedite the check-in process. Please DO NOT fill out the form that is attached to the link in the reminder text you will receive prior to your appointment. That link is for patients seeing other doctors within the practice. If you have dental insurance, please bring a copy of your current insurance card to your appointment. We will work with you to ensure that you receive the maximum benefits to which you are entitled based on your policy. We also request that you bring a separate list of all prescription and over-the-counter medications that you are currently taking, with the correct dosages, if you are unable to fit all medications that you are taking on the appropriate line of the enclosed health history form.

The first step toward complete oral health is a thorough examination and diagnosis of the tooth or teeth in question. Part of a good diagnosis requires that symptoms not be masked by pain medication so we can perform diagnostic tests accurately. We understand that you may be experiencing pain with the offending tooth, but we request that you not take any pain medications (including, but not limited to, Advil, Aspirin, Ibuprofen, Tylenol, Motrin, etc.) the day that you are scheduled for evaluation, if possible. If you take these medications for other systemic ailments, you can bring it to your appointment and take the medication following diagnostic testing. We encourage you to take all other daily medications, that are not pain relievers, as you regularly do. And please do not hesitate to eat a good meal before your appointments, as your appointments could be a couple of hours long, and we would like you to be comfortable while you are here. You are also welcome to bring headsets/earphones with audio players for your listening pleasure during your appointment.

Our team is devoted to making your appointment as pleasant and enjoyable as possible. We want our patients to make informed choices by fully understanding the diagnosis and being made aware of all treatment options. Feel free to ask questions of our staff. We are here to help you. Thank you for choosing our practice. We look forward to meeting you soon.

Sincerely,

Dr. Paulomi Shah & Staff

Paulomi Shah, D.D.S., M.S.D.

-Practice Limited to Contemporary Endodontics–

TODAY'S DATE _____ DATE OF BIRTH _____

Patient's Name _____ Last _____ First _____ Initial _____

If Child: Parent's Name _____ Last _____ First _____ Initial _____

Mailing Address _____

City _____ State _____ Zip _____

Telephone: Res. _____ Cell. _____

Patient/Parent Employed By _____

Present Position _____ How Long Held _____

Who is Responsible for This Account _____ Relationship to Patient _____

Method of Payment: ☐ Insurance ☐ Credit Card ☐ Cash

Patient/Parent Social Security No. _____

Name and Telephone Number of Someone Not Living With You to Notify in Case of Emergency

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's *NOTICE OF PRIVACY PRACTICES.* I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed on the yellow information sheet. I further understand that the practice will offer me updates of this *NOTICE OF PRIVACY PRACTICES* should it be amended, modified, or changed in any way."

Patient or Representative Name [please print] _____

Patient or Representative Signature _____ Date _____

☐ Patient refused to sign

☐ Patient was unable to sign because _____

CONSENT

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that any necessary collection charges may be added to my account.

4. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date ____/____/____

Parent or Responsible Party _____ Relationship to Patient _____

Please Complete Back Page

Reviewed by Doctor _____ Date _____

History Review and Significant Findings: _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	REVIEWED BY
_____	_____	NONE ☐	_____	DR. _____
_____	_____	NONE ☐	_____	DR. _____
_____	_____	NONE ☐	_____	DR. _____
_____	_____	NONE ☐	_____	DR. _____
_____	_____	NONE ☐	_____	DR. _____

Dental / Medical History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No
Do you floss daily? ☐ Yes ☐ No
Brush daily? ☐ Yes ☐ No
Would you like fresher breath? ☐ Yes ☐ No
Whiter teeth? ☐ Yes ☐ No
Have you ever experienced/had:
Does heat cause pain? ☐ Yes ☐ No
Does cold cause pain? ☐ Yes ☐ No
Do you have pain on biting? ☐ Yes ☐ No
Is pain consistent? ☐ Yes ☐ No
Is pain dull? ☐ Yes ☐ No
Is pain sharp? ☐ Yes ☐ No
Do you have swelling? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Have you taken antibiotics today? ☐ Yes ☐ No
Are you anxious about dental treatment? ☐ Yes ☐ No
Is there anything else about having dental treatment that you would like to know? ☐ Yes ☐ No
If "Yes", what: _____

_____

_____

1. Are you or have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
   If yes, for what? _____
   Physician's Name _____ Phone _____
2. Are you taking any prescription/over the counter medications? ☐ Yes ☐ No
   If yes, please list name and dosage _____
3. Are you aware of having an allergic (or adverse reaction) to any of the following?
   Penicillin ☐ Yes ☐ No Tetracycline ☐ Yes ☐ No Latex ☐ Yes ☐ No Erythromycin ☐ Yes ☐ No
   Aspirin ☐ Yes ☐ No Dental Anesthetics ☐ Yes ☐ No Codeine ☐ Yes ☐ No Other ☐ Yes ☐ No
   Please list any other drugs that you are allergic to: _____
4. Have you been a patient in the hospital during the past 5 years? ☐ Yes ☐ No
5. **Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.**

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Hepatitis B (serum)	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	Venereal Disease	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive (Aids)	Yes	No
High Blood Pressure	Yes	No	Emphysema	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Chronic Cough	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Tuberculosis	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Asthma	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Arthritis/Rheumatism	Yes	No	Latex Sensitivity	Yes	No	Neurological Disorders	Yes	No
Cortisone Medicine	Yes	No	Allergies or Hives	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care	Yes	No
Drug Addiction	Yes	No	Cancer	Yes	No	Tumors	Yes	No

6. Do you have or have you had any disease, condition, or problem not listed? Yes No
   If yes, please list: _____

Women only: Are you: Pregnant? Yes,_____ Months No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____