DAVID SCHMIDT, D.D.S.

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name ______________________ Soc. Sec. # ______________

Address ______________________

City ______________ State ______ Zip ________ Home Phone ______________

Cell Phone ______________ Email ______________

Sex ❑ M ❑ F Age _______ Birthdate ______________ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Child

Patient Employed by ______________ Occupation ______________

Business Address ______________ Business Phone ______________

Business Email ______________________

If Full Time Student School Name ______________________

Whom may we thank for referring you? ______________________

Person Responsible for Account ______________ Relationship to Patient ______________

PRIMARY INSURANCE

Insurance Company Name: ______________ Phone: ______________

Insured's Name: ______________ Relationship to Patient: ______________

Insured's ID #: ______________ Insured's Date of Birth: ______________

Insured's Employer: ______________ Employer's Phone #: ______________

Work Address: ______________________

Group # ______________ Effective Date: ______________

SECONDARY INSURANCE

Insurance Company Name: ______________ Phone: ______________

Insured's Name: ______________ Relationship to Patient: ______________

Insured's ID #: ______________ Insured's Date of Birth: ______________

Insured's Employer: ______________ Employer's Phone #: ______________

Work Address: ______________________

Group # ______________ Effective Date: ______________

AUTHORIZATION

I have reviewed the information on the front and back of this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I grant permission to David Schmidt, D.D.S., to use my name, photograph, video, audio recording and/or testimonial in marketing or teaching materials used for his dental practice, including Dr. Schmidt's website. Check the box no ❑ if you do not agree.

Signature: ______________________ Date: ______________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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.

DENTAL HISTORY

What would you like us to do today? ________________ Are you in dental discomfort today? ________
Former Dentist ________________
Date of last dental care ________________ Date of last x-rays ________________
Check (✓) if you have had problems with any of the following:

- ❏ Bad breath
- ❏ Bleeding gums
- ❏ Clicking or popping jaw
- ❏ Food collection between teeth
- ❏ Grinding or clenching teeth
- ❏ Loose teeth or broken fillings
- ❏ Periodontal (gum) treatment
- ❏ Sensitivity to cold
- ❏ Sensitivity to hot
- ❏ Sensitivity to sweets
- ❏ Sensitivity when biting
- ❏ Sores or growths in mouth

How often do you brush? ________________ How often do you floss or use toothpicks? ________________
How do you feel about the appearance of your teeth? ________________
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❏ Y ❏ N
Other information about your dental health or previous treatment. ________________

Notify in case of emergency ________________ **Home Phone** ________________
Cell Phone ________________ **Business Phone** ________________
Email ________________

MEDICAL HISTORY

Physician's name ________________ Phone ________________
Date of last visit ________________ Have you had any serious illness or operations? ❏ Y ❏ N
If yes, describe ________________
Are you currently under physician care? ❏ Y ❏ N If yes, describe ________________
Have you ever had a blood transfusion? ❏ Y ❏ N If yes, describe ________________
Have you ever taken Fen-Phen/Redux? ❏ Y ❏ N
Women: Are you pregnant or trying to get pregnant? ❏ Y ❏ N Nursing ❏ Y ❏ N Taking birth control pills? ❏ Y ❏ N
Please check (✓) if you have had any of the following:

- ❏ AIDS/HIV Positive
- ❏ Anaphylaxis
- ❏ Anemia
- ❏ Arthritis, Rheumatism
- ❏ Artificial Heart Valves
- ❏ Artificial Joints
- ❏ Asthma
- ❏ Back problems
- ❏ Blood disease
- ❏ Cancer
- ❏ Chemical dependency
- ❏ Chemotherapy
- ❏ Circulatory problems
- ❏ Cortisone treatments
- ❏ Cough, persistent
- ❏ Cough up blood
- ❏ Diabetes
- ❏ Epilepsy
- ❏ Fainting
- ❏ Food allergies
- ❏ Glaucoma
- ❏ Headaches
- ❏ Heart murmur
- ❏ Heart problems
  Describe ________________
- ❏ Hemophilia/Abnormal Bleeding
- ❏ Herpes
- ❏ Hepatitis
- ❏ High blood pressure
- ❏ Jaw pain
- ❏ Kidney disease or malfunction
- ❏ Latex allergy
- ❏ Mitral valve prolapse
- ❏ Nervous problems
- ❏ Pacemaker/Heart surgery
- ❏ Psychiatric care
- ❏ Rapid weight gain or loss
- ❏ Radiation treatment
- ❏ Recreational drugs
- ❏ Respiratory disease
- ❏ Rheumatic/Scarlet fever
- ❏ Shingles
- ❏ Shortness of breath
- ❏ Skin rash
- ❏ Spina Bifida
- ❏ Stroke
- ❏ Surgical implant
- ❏ Swelling of feet or ankles
- ❏ Thyroid disease or malfunction
- ❏ Tobacco habit
- ❏ Tonsillitis
- ❏ Tuberculosis
- ❏ Ulcer/Colitis
- ❏ Venereal disease

What medication, vitamins or herbal supplements are you taking?
____
____

Does patient have drug allergies? If yes, list all:
____
____

MEDICAL HISTORY UPDATE – (For Office Use Only)

Have there been any changes in your health since your last dental appointment? Yes_____ No______
If yes, for what condition? ________________
What medication, vitamins or herbal supplements are you taking? ________________
____

Patient Signature: ________________ Date: ________________