

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 _____ SSN _____
Last First MI

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

In case of Emergency:
Notify _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Primary Insurance

Person Responsible for Account _____
Last First MI

Relationship to Patient _____ Birthdate _____ SSN _____

Address (If different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name(s) of other dependent(s) under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____
Last First MI

Relationship to Patient _____ Birthdate _____ SSN _____

Address (If different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name(s) of other dependent(s) under this plan _____

Please Complete All Pages of Form

Dental History

Primary Reason for Visit _____ Are you in dental discomfort today? Yes No

Former Dentist _____ Address _____

Phone _____ Email _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush? _____ Floss? _____

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

Medical History

Physician's Name _____ Phone _____

Date of last visit _____

Have you had any serious illnesses 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, give approximate dates _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) yes or no if you have/have had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Joints | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex , wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapsed | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer(s)/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | | |

Are you currently taking any medications? If yes, list all _____

Do you have any drug allergies? If yes, list all _____

Please Complete All Pages of Form

Appointments: A minimum charge will be made for missed or cancelled appointments without prior notification of 24 hours. Once an appointment has been made, please remember this time has been reserved for the patient.

Insurance: We will assist in filing a claim with your insurance company, however all fees are the sole responsibility of the patient/responsible party.

Authorization

I have reviewed the information on this document, 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.

Signature _____ Date _____

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

Scheidt's Cosmetic and Family Dentistry