

Schuylkill Dental Medicine

Healthy Beautiful Smiles™

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www.schuylkilldental.com

FOR OFFICE USE ONLY		
DR _____	HX _____	BP _____

Patient Information

Patient Name: _____ Date of Birth: _____ Age: _____
Last, First, MI

M F Married Separated Divorced Widowed Single Child Height: _____ Wt: _____

Social Security #: _____ Phone (Home): _____ (Work): _____

Address: _____ (Cell): _____
Street, Apartment #

_____ E-Mail: _____
City, State, Zip Code

College Students: Full-time Part-time Expected date of graduation: _____

College Name and Location: _____

Confidential Medical and Dental Information

Do you have, or are you being treated for, any of the following? Please check those that apply:

* If yes to any of these conditions, please call prior to your appointment. Antibiotics may be required before dental treatment.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Alcoholism
<input type="checkbox"/> Anemia
<input type="checkbox"/> Angina, Chest Pain
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Heart Valve*
<input type="checkbox"/> Artificial Joints*
<input type="checkbox"/> Asthma, Emphysema
<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> Cancer
<input type="checkbox"/> CFS/MPD/Fibromyalgia
<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Cold Sores, Herpes
<input type="checkbox"/> Coronary Artery Stent*
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dizziness, Fainting
<input type="checkbox"/> Drug Use, Addiction
<input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Epilepsy, Seizures
<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Fen-Phen/Redux Use*
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Head Injury
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur*
<input type="checkbox"/> Hepatitis, Jaundice
<input type="checkbox"/> Hi/Lo Blood Pressure
<input type="checkbox"/> Hi/Lo Blood Sugar
<input type="checkbox"/> HIV+, AIDS
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Leukemia
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Mitral Valve Prolapse*
<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Reflux/GERD
<input type="checkbox"/> Rheumatic Fever*
<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Sexual Disease/STD
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumors or Growths | <p>Women</p> <input type="checkbox"/> Pregnant
<input type="checkbox"/> Nursing
<input type="checkbox"/> Birth Control Pills <p>Allergies</p> <input type="checkbox"/> Aspirin
<input type="checkbox"/> Codeine
<input type="checkbox"/> Latex
<input type="checkbox"/> Novocain
<input type="checkbox"/> Penicillin
<input type="checkbox"/> Sulfa Drugs
<input type="checkbox"/> Other Allergy |
|---|--|---|--|

Your Physicians/Specialists (Name, Group or Hospital, City, State):

Last Exam or Office Visit: _____ Reason: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

Are you taking any of the following medicines? Please check those that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Antibiotics or Sulfa Drugs | <input type="checkbox"/> Antidepressants or Tranquilizers | <input type="checkbox"/> Inhalers |
| <input type="checkbox"/> Cortisone (Steroids) | <input type="checkbox"/> Heart Medicine | <input type="checkbox"/> Allergy Medicine |
| <input type="checkbox"/> Insulin or Diabetes Medicine | <input type="checkbox"/> Blood Pressure Medicine | <input type="checkbox"/> Other Medicine |
| <input type="checkbox"/> Aspirin or Blood Thinners | <input type="checkbox"/> Nitroglycerin | |

Please list all current medications (include non-prescription and herbal/alternative): _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

Who should we contact in the event of an emergency (Name, relationship, phone number):

Preferred Hospital: _____

How did you hear about our office? Friend/Relative _____

Insurance Plan Internet Advertisement _____ Other

Name of Previous Dentist: _____ Location: _____

Date of your Last Dental Appointment: _____ Last X-rays: _____ Last Cleaning: _____

Why did you leave your previous dentist? _____

Do you think you have any of the following? Please check those that apply:

Do you:

- | | | | | |
|--|--|--|---|---------------------------------------|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Clench or Grind | <input type="checkbox"/> Lost Fillings | <input type="checkbox"/> Tartar and Stain | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Broken Teeth | <input type="checkbox"/> Gum Disease | <input type="checkbox"/> Mouth Ulcers | <input type="checkbox"/> TMJ or Jaw Pain | <input type="checkbox"/> Chew Tobacco |
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Sensitive Teeth | <input type="checkbox"/> Toothaches | |

How often do you have dental exams? _____

How often do you brush your teeth? _____ How often do you floss? _____

Are any of your teeth sensitive to: Hot Cold Sweets Biting Chewing

Please check if you have had any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Braces | <input type="checkbox"/> Gum treatment |
| <input type="checkbox"/> Frequent cold sores or mouth ulcers | <input type="checkbox"/> Loose teeth or change in bite |
| <input type="checkbox"/> Gums that bleed or hurt | <input type="checkbox"/> Serious mouth or head injury |
| <input type="checkbox"/> A bite plate or mouthguard | |

Have you experienced:

- Pain, clicking or popping in jaw
- Difficulty in opening or closing your mouth

Do you:

- Clench or grind your teeth while awake or asleep
- Wake up with a headache, sore or tight jaw
- Bite your nails or hold foreign objects with your teeth (pens, pencils, tools, etc)
- Lift weights
- Play team sports competitively or for recreation

Is there anything about your teeth, gums, or smile you would like to change? Yes No

Would you like to have whiter teeth? Yes No

Responsible Party Information

The person responsible for payment is: Patient Spouse Parent/Guardian Other

Responsible Party Name: _____ Date of Birth: _____
Last, First, MI

Social Security #: _____ Phone (Home): _____ (Work): _____

Address: _____
Street, Apartment #

City, State, Zip Code

Employer Name: _____ Occupation: _____

Employer Address: _____
City State

Driver's License: State _____ License # _____

Dental Insurance Information

Important: Bring Your Insurance Card to Each Appointment

Primary

Insured's Name: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Birth Date: _____ Ins ID #: _____ Ins Group #: _____

Employer Name & Address: _____

Patient's relationship to insured: Self Spouse Child Other

Insurance Carrier: _____

Do you have any other Dental Insurance Coverage? Yes No

Consent for Services

I hereby authorize Schuylkill Dental Medicine to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dental Office to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that undergoing any dental procedure with or without the use of anesthetic agents embodies a certain risk.

I understand that, as a condition of treatment, all emergency dental services, and any dental services performed without previous financial arrangements, must be paid for in full by cash, check, or credit card at the time services are performed. I understand that interest or late payment fees will be charged if my account becomes past due. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any filing costs, court fees, collection fees, and attorney fees incurred to effect collection of this account or future outstanding accounts.

If I carry dental insurance, I understand that all dental services furnished are charged directly to me and that I am personally responsible for payment of all dental services. I understand that the Dental Office will help prepare insurance forms or assist in making collections from insurance companies, and will credit any such collections to my account. However, I acknowledge that Schuylkill Dental Medicine cannot render services on the assumption that charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability, but I understand that this is an estimate only, not a guarantee of coverage. I hereby authorize release of any information required to complete or process insurance claims and I authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me.

*I have read the above conditions of treatment and agree to their content.
To the best of my knowledge, all of the answers and information provided are true and correct.*

Signature Date Patient Father Mother Guardian