Schuylkill Dental Medicine

42 E. Sunbury St., Minersville, PA 17954   (570) 544-4785   www.schuylkilldental.com

SDM HX_INIT.doc   BP___________ Pulse _________ SpO_2 _________ Staff__________ Dr______

PATIENT – PLEASE MAKE ANY NECESSARY CORRECTIONS TO PRINTED INFORMATION

Name	
Address Line 1	
Address Line 2	
City, State, Zip	
Employer Name	
Home Phone	
Work Phone	
Cell Phone	
Other Phone	
E-mail	
Social Security Number	
Date of Birth	
Sex	

Height _______ Weight _______ Age _______ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

DO YOU HAVE, OR ARE YOU BEING TREATED FOR, ANY OF THE FOLLOWING?

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Arrhythmia (irregular beat)
- ☐ Congenital Heart Defect
- ☐ Valve Disease or Murmur
- ☐ Artificial Heart Valve
- ☐ Pacemaker / Defibrillator
- ☐ Coronary Artery Stent
- ☐ Stroke
- ☐ Bleeding Problems
- ☐ Blood Cell Disorder

Nervous System
- ☐ Seizures
- ☐ Depression
- ☐ Panic Attacks
- ☐ Psychosis or Mania
- ☐ Multiple Sclerosis
- ☐ Headaches / Migraines
- ☐ Alcohol Abuse
- ☐ Drug / Substance Abuse
- ☐ Physical / Mental Impairment
- ☐ Psychiatric Treatment

Infections
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ STD (Sexual Disease)

Respiratory
- ☐ COPD
- ☐ Asthma / Emphysema
- ☐ Sleep Apnea

Endocrine
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Immune Disorder
- ☐ (Women) Pregnant
- ☐ (Women) Breast Feeding

Excretory
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Reflux / Ulcers / GERD
- ☐ Colitis / Diverticulitis

Miscellaneous
- ☐ Cancer
- ☐ CFS/MPD/Fibromyalgia
- ☐ Osteoporosis
- ☐ Artificial Joint
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Glaucoma
- ☐ Leukemia

ALLERGIES

- ☐ Aspirin
- ☐ Benzocaine
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Ibuprofen
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Sulfites
- ☐ Tylenol
- ☐ Other Allergy:

Please list any medical problems not shown above:

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING, INCLUDING NON-PRESCRIPTION PRODUCTS:

Your Doctor(s):

EMERGENCY CONTACT: Name, Relationship, Phone number / Preferred Doctor / Preferred Hospital

Previous Dentist: ______________________________ City/State: _________________ Last Appt: _______________

DENTAL CONCERNS:

☐ Bleeding Gums	☐ Cold Sores	☐ Lost Fillings	☐ Toothache	DO YOU
☐ Broken Teeth	☐ Mouth Ulcers	☐ Sensitive Teeth	☐ Bad Breath	☐ Smoke
☐ Cavities	☐ Gum Disease	☐ Tartar and Stain	☐ Dry Mouth	☐ Use Chew Tobacco
☐ Clench or Grind	☐ Loose Teeth	☐ TMJ or Jaw Pain	☐ Want Whiter Teeth	

IS THERE ANYTHING ABOUT YOUR TEETH, GUMS, OR SMILE YOU WOULD LIKE TO CHANGE? ☐ Yes ☐ No
Please explain:

THE PERSON RESPONSIBLE FOR PAYMENT IS: ☐ MYSELF (SKIP THIS SECTION) ☐ SOMEONE ELSE (COMPLETE THIS SECTION)

Name: ____ ☐ M ☐ F Relationship to Patient: ___________________
Last First MI

Address: ____ City _______________ State ________ ZIP _________

SSN: _____________________ Birth Date: _________ E-Mail Address: ____________________________________

Phone: __________________________ ☐ Cell ☐ Home ☐ Work Employer: ______________________________

DENTAL INSURANCE

Primary Carrier:	
Group Name:	
Secondary Carrier:	
Group Name:	

PLEASE CHOOSE AN OPTION FOR NON-INSURED TREATMENT, INSURANCE CO-PAYS AND NON-COVERED SERVICES:

__ I will pay at each appointment using Cash, Check, Visa, Mastercard or Discover.

__ I will pre-pay each treatment cycle using one of the above payment methods.

__ I authorize automatic billing of my credit card for any balance due following receipt of insurance payment:

Card type: _______________________ Card number: _________________________________
Expiration date: ___________________ Security Code: _______
Name on Card: ____________________ Signature: ____________________________________

__ I would like to apply for financing through Regency Finance Company (low monthly payment options, no up-front costs, and no prepayment penalties).

CONSENT FOR SERVICES + INSURANCE ASSIGNMENT AND RELEASE

I hereby authorize Schuylkill Dental Medicine to take x-rays, study models, photographs, and any other diagnostic aids deemed necessary to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Schuylkill Dental Medicine 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, and I understand that undergoing any dental procedure with or without the use of anesthetic agents embodies a certain risk.

I understand that I am personally responsible for payment of all dental services regardless of insurance coverage, and that payment is due at the time services are rendered. 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 insurance benefits otherwise payable to me. 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 will be responsible for any fees incurred to effect collection of this account.

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

Printed Name:____