

DENTAL HISTORY

Name _____ Nickname _____ Age _____

How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO

GUM AND BONE



5. Do your gums bleed or are they painful when brushing or flossing _____ YES NO
6. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ YES NO
7. Have you ever noticed an unpleasant taste or odor in your mouth _____ YES NO

BITE AND JAW JOINT



8. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
9. Do you clench your teeth in the daytime or make them sore? _____ YES NO
10. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ YES NO
11. Do you wear or have you ever worn a bite appliance? _____ YES NO

SMILE CHARACTERISTICS



12. Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
13. Have you ever whitened (bleached) your teeth? _____ YES NO
14. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____ YES NO
15. Have you been disappointed with the appearance of previous dental work? _____ YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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MEDICAL HISTORY

Patient Name _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

		YES	NO			YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>		<input type="checkbox"/>	27. arthritis _____	<input type="checkbox"/>		<input type="checkbox"/>
2. an allergic reaction to _____	<input type="checkbox"/>		<input type="checkbox"/>	28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine				29. glaucoma _____	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> penicillin				30. contact lenses _____	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> erythromycin				31. head or neck injuries _____	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> tetracycline				32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> sulfa				33. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> local anesthetic				34. viral infections and cold sores _____	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> fluoride				35. any lumps or swelling in the mouth _____	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)				36. hives, skin rash, hay fever _____	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> latex				37. STI / STD / HPV _____	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> other _____	<input type="checkbox"/>		<input type="checkbox"/>	38. hepatitis (type ____)	<input type="checkbox"/>		<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>		<input type="checkbox"/>	39. HIV / AIDS _____	<input type="checkbox"/>		<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>		<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>		<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>		<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>		<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>		<input type="checkbox"/>	42. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>		<input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>		<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>		<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>		<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>		<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>		<input type="checkbox"/>	45. alcohol / recreational drug use _____	<input type="checkbox"/>		<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>		<input type="checkbox"/>				
11. anemia or other blood disorder _____	<input type="checkbox"/>		<input type="checkbox"/>				
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>		<input type="checkbox"/>				
13. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>		<input type="checkbox"/>				
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>		<input type="checkbox"/>				
15. asthma _____	<input type="checkbox"/>		<input type="checkbox"/>				
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)							
17. kidney disease _____	<input type="checkbox"/>		<input type="checkbox"/>				
18. liver disease _____	<input type="checkbox"/>		<input type="checkbox"/>				
19. jaundice _____	<input type="checkbox"/>		<input type="checkbox"/>				
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>		<input type="checkbox"/>				
21. hormone deficiency _____	<input type="checkbox"/>		<input type="checkbox"/>				
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>		<input type="checkbox"/>				
23. diabetes (HbA1c = _____)	<input type="checkbox"/>		<input type="checkbox"/>				
24. stomach or duodenal ulcer _____	<input type="checkbox"/>		<input type="checkbox"/>				
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>		<input type="checkbox"/>				
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>		<input type="checkbox"/>				

ARE YOU:

46. presently being treated for any other illness _____				46. presently being treated for any other illness _____			
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>		<input type="checkbox"/>	47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>		<input type="checkbox"/>
48. taking medication for weight management _____	<input type="checkbox"/>		<input type="checkbox"/>	48. taking medication for weight management _____	<input type="checkbox"/>		<input type="checkbox"/>
49. often exhausted or fatigued _____	<input type="checkbox"/>		<input type="checkbox"/>	49. often exhausted or fatigued _____	<input type="checkbox"/>		<input type="checkbox"/>
50. experiencing frequent headaches _____	<input type="checkbox"/>		<input type="checkbox"/>	50. experiencing frequent headaches _____	<input type="checkbox"/>		<input type="checkbox"/>
51. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>		<input type="checkbox"/>	51. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>		<input type="checkbox"/>
52. taking birth control pills _____	<input type="checkbox"/>		<input type="checkbox"/>	52. taking birth control pills _____	<input type="checkbox"/>		<input type="checkbox"/>
53. currently pregnant _____	<input type="checkbox"/>		<input type="checkbox"/>	53. currently pregnant _____	<input type="checkbox"/>		<input type="checkbox"/>
54. prostate disorders _____	<input type="checkbox"/>		<input type="checkbox"/>	54. prostate disorders _____	<input type="checkbox"/>		<input type="checkbox"/>

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
(i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____

CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor and mutually agreed upon, for the purposes of diagnosis or educational presentation.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf and that of my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1½% finance charge (18% APR) may be added to my account.

Patient _____ Date ____ / ____ / ____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the physician, dentist, or other health care provider to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate, or evaluate any claim for benefit.

If my coverage is under a group master agreement held by my employer, and association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective for up to five years from this date.

Patient _____ Date ____ / ____ / ____

Parent or Responsible Party _____

AUTHORIZATION FOR SUBMISSION OF CLAIMS & ASSIGNMENT OF BENEFITS

I authorize the office of **Schaffer Dental Excellence** to submit claims for payment for services to my health care service plans or insurance companies on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

Patient _____ Date ____ / ____ / ____

Parent or Responsible Party _____

I understand that **Schaffer Dental Excellence** will make every effort possible to assist me with my insurance coverage. **Schaffer Dental Excellence** allows no more than 90 days for the insurance to submit payment. Any outstanding claims past the 90-day mark will be my responsibility. If the insurance submits a payment following the deadline, **Schaffer Dental Excellence** will reimburse me or credit my account. It is my responsibility to pay any deductible, co-payment, or any other balance not paid by my insurance company. **Schaffer Dental Excellence** requires my estimated portion at the time treatment is rendered.

CANCELLATION

I understand that should I need to cancel an appointment time reserved specifically for me, I will notify the dental office at least 48 hours in advance so that my time may be utilized by another patient. If I fail to give a minimum of 48 **business** hours notice, I will be required to pay a fee of \$50 per scheduled hour before a new appointment time will be made for me.

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PATIENT INFORMATION

Name (Mr., Mrs., Ms., Dr.,) _____
Last First Middle
Residence/Address _____ City _____ Zip _____
Business/Address _____ City _____ Zip _____
Home Phone # _____ Business Phone # _____
Cell Phone # _____ E-mail Address _____
Date of Birth ____/____/____ Social Security # _____
If patient is a minor, Name of mother and father _____
Place of Employment _____
Occupation/Former Occupation _____

SPOUSE INFORMATION

Name _____ Date of Birth ____/____/____
Employer _____ Occupation _____

In Case of Emergency

Person to Contact _____ Phone # _____
Friend/Relative Not Living with Patient _____ Phone # _____

REFERRAL SOURCE

Whom may we thank for referring you? _____
If not referred, how did you hear about us? _____

RESPONSIBLE PARTY (If Other Than Self)

Person Responsible for Payment of Account _____ Relationship _____
Mailing Address _____ City _____ State _____
Date of Birth ____/____/____ Phone # _____ Zip _____

INSURANCE INFORMATION

Name of Primary Dental Insurance Plan _____
Policy or Group # _____ Subscriber's Name (if different) _____ SSN of Subscriber _____
Name of Secondary Dental Insurance Plan _____
Policy or Group # _____ Subscriber's Name (if different) _____ SSN of Subscriber _____

There will be a charge for broken appointment without 48 hours notice. I understand that responsibly for payment for dental services provided in this office for myself or my dependent is mine, regardless of insurance benefits. I also understand that payment is due and payable at the time services are rendered. A finance charge will be added, if payment is not received within 90 days of service. I realize that failure to keep this account current may result in you being unable to provide additional dental services.

Signature _____ Date ____/____/____