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

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to _____	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____	☐	☐
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma_____	☐	☐
16. kidney disease _____	☐	☐
17. liver disease _____	☐	☐
18. jaundice _____	☐	☐
19. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
20. hormone deficiency _____	☐	☐
21. high cholesterol or taking statin drugs _____	☐	☐
22. diabetes (HbA1c =_____) _____	☐	☐
23. stomach or duodenal ulcer _____	☐	☐
24. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
25. osteoporosis/osteopenia (i.e. taking bisphosphonates)_____	☐	☐

	YES	NO
26. arthritis _____	☐	☐
27. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
28. glaucoma _____	☐	☐
29. head or neck injuries_____	☐	☐
30. epilepsy, convulsions (seizures) _____	☐	☐
31. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
32. viral infections and cold sores _____	☐	☐
33. any lumps or swelling in the mouth_____	☐	☐
34. hives, skin rash, hay fever _____	☐	☐
35. STI / STD / HPV _____	☐	☐
36. hepatitis (type ___) _____	☐	☐
37. HIV / AIDS _____	☐	☐
38. tumor, abnormal growth_____	☐	☐
39. radiation therapy_____	☐	☐
40. chemotherapy, immunosuppressive medication _____	☐	☐
41. psychiatrictreatment _____	☐	☐
42. antidepressant medication _____	☐	☐

ARE YOU:	YES	NO
43. presently being treated for any other illness _____	☐	☐
44. taking medication for weight management _____	☐	☐
45. experiencing frequent headaches_____	☐	☐
46. a smoker, smoked previously or use smokeless tobacco_	☐	☐
47. taking birth control pills _____	☐	☐
48. currentlypregnant _____	☐	☐

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 _____

ASA _____ (1-6)

MEDICAL 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**

DENTAL HISTORY

	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] ________________	☐	☐
H0 Have you ever had trouble getting numb or had any reactions to local anesthetic?________________	☐	☐
o0 Do your gums bleed or are they painful when brushing or flossing ________________	☐	☐
n0 Have you ever been treated for gum disease or been told you have lost bone around your teeth? ________________	☐	☐
p0 Have you ever noticed an unpleasant taste or odor in your mouth? ________________	☐	☐

BITE, JAW JOINT AIRWAY

	YES	NO
6. 52 è2dz KI·ØŜ LǊ2ōfŜYă ǿǈűK è2dzǊ ʔI·ǿ ʔ2ǈyűK óLJI·ǈyΣ ă2dzyŘăΣ fǈYǈűŜŘ 2LJŜyǈyƎΣ f2ŎʅǈyƎΣ LJ2LJLJǈyƎú ψψψψψψψψψψψψψψψψψψψψψ_______ψψψψψ	☐	☐
7. 52 è2dz ŎfŜyŎK è2dzǊ űŜŜűK ǈyűKŜ ŘI·è űǈYŜ 2Ǌ YI·ʅŜ űKŜY ă2ǊŜK ψψψψψψψψψψψψψψψψψψψψψψψ___________________________ψψψψψψ	☐	☐
8. 52 è2dz KI·ØŜ I·yê LǊ2ōfŜYă ǿǈűK ăfŜŜLJ óǈŜ ǊŜăűfŜăăyŜăăúΣ ǿI·ʅŜ dzLJ ǿǈűK I· KŜI·ŘI·ŎKŜ 2Ǌ I·yI·ǿI·ǊŜyŜăă 2Ŧ è2dzǊ űŜŜűKK ψψ__________ψψψψ	☐	☐
9. 52 è2dz ǿŜI·Ǌ 2Ǌ KI·ØŜ è2dz ŜØŜǊ ǿ2ǊyI· ōǈűŜ I·LJLJfǈI·yŎŜK ψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψ_____________ψψψψ	☐	☐
10. !ǊŜ è2dz dzăǈyƎ 2Ǌ KI·ØŜ dzăŜŘ / t ! tK ψψψψψψψψψψψψψψψψψψψψψψψψψψψψ____ψψψψψψψψψψψψψψ	☐	☐
11. 52 è2dz ǿI·ʅŜ dzLJ ŦŜŜfǈyƎ dzyǊŜŦǊŜăKŜŘK____ψψψψψψψψψψψψψψψψψψψψψψψψ	☐	☐

SMILE CHARACTERISTICS

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

Patient's Signature ____ Date ______________________

Doctor's Signature ____ Date ______________________

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Dental Excellence

Earth Friendly Dentistry

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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Schaffer Dental Excellence
Phone: 858-481-1148 • Fax: 858-792-9143
contactus@schafferdental.com • www.schafferdental.com

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 ____/____/____