

# WELCOME

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

## PATIENT INFORMATION

Date \_\_\_\_\_ Occupation \_\_\_\_\_  
SS/HIC/Patient ID # \_\_\_\_\_ Patient Employer/School \_\_\_\_\_  
Patient Name \_\_\_\_\_ Employer/School Address \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
E-mail \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## DENTAL INSURANCE

Subscriber's Name \_\_\_\_\_ Is patient covered by secondary insurance?  Yes  No  
Relationship to patient \_\_\_\_\_ Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Group # \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## PHONE NUMBERS

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
Spouse's Work (\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Former Dentist \_\_\_\_\_ City /State \_\_\_\_\_  
Date of last dental visit \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_ How often do you floss? \_\_\_\_\_  
How often do you brush \_\_\_\_\_

**Please () "yes" or "no" to indicate if you have had any of the following:**

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums while brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums while flossing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding or clenching teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets or sour	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth of broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Pharmacy \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Please (☑) "yes" or "no" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Have you ever had or been diagnosed with:**

Artificial Heart Valves  Yes  No  
 Artificial Joints, Screws, Pins, etc.  Yes  No  
 Bleeding abnormally, with extractions or surgery  Yes  No  
 Blood Disease  Yes  No  
 Congenital Heart Lesions  Yes  No  
 Heart Murmur  Yes  No  
 Mitral Valve Prolapse  Yes  No  
 Pacemaker  Yes  No  
 Rheumatic Fever  Yes  No

Are you currently taking blood thinners.  Yes  No

**Please PRINT all medications now taking:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Are you allergic to:**

Aspirin  Yes  No  
 Barbiturates  Yes  No  
 Codeine  Yes  No  
 Ibuprofen  Yes  No  
 Latex  Yes  No  
 Local Anesthesia  Yes  No  
 Metals (e.e. gold)  Yes  No  
 Penicillin  Yes  No

Other \_\_\_\_\_

**Have you ever had any complications following dental treatment?**  Yes  No

If yes, please describe \_\_\_\_\_

Have you ever been hospitalized or do you have any other concerns?  Yes  No

If yes, please describe \_\_\_\_\_

**Women:** Are you pregnant?  Yes  No

Due date \_\_\_\_\_

Are you nursing?  Yes  No

Taking birth control pills?  Yes  No

**\* INSURANCE ASSIGNMENT OF BENEFITS**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. **Insurance Assignment:** I certify that I, and /or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
 Name of Insurance Company(ies)

Dr. John Schwerer all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above - named doctor may use my health care information and may disclose such information to the above - named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

**\* MINOR/CHILD RELEASE**

I, being the parent or guardian of \_\_\_\_\_ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

**\* ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.**

I acknowledge that I have received a copy of this offices Notice of Privacy PRACTICES.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Relationship to Patient

**KEEPING APPOINTMENTS**

Keeping your scheduled appointments is very important to your treatment success

If you cannot keep you appointment our office will need 48 hours notice. Less than 48 hours notice is considered a broken appointment.

We understand that occasionally, unexpected events arise. In the unlikely event you have to give less than 48 hours notice, and break an appointment we will consider this a one time personal emergency.

In the unlikely event you must break a second appointment we will no longer be able to reserve appointments for you.

I have read and understand this broken appointment procedure.

Signature: \_\_\_\_\_