SCHEICH FAMILY DENTISTRY

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WELCOME TO OUR PRACTICE AND THANK YOU FOR TRUSTING US WITH YOUR DENTAL NEEDS!

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last First Initial

Address _____ City _____ State _____ Zip _____

Home Phone _____ Other Phone _____ Email address _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer _____ Occupation _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

FAMILY INFORMATION

Please list the names and birthdates of your immediate family members

Name _____ Birthdate _____

Name _____ Birthdate _____

Name _____ Birthdate _____

Name _____ Birthdate _____

INSURANCE INFORMATION

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____

Insurance Company _____

Phone # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Is patient covered by additional dental insurance? ☐ Yes ☐ No

If yes, what is the subscriber's name? _____ Soc. Sec. # _____

Insurance Company _____

Phone # _____ Group # _____ Subscriber # _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Previous Dentist _____ Date of last dental x-rays _____

Address _____

Check (√) if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping in jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweet
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

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

Additional questions or concerns _____

(CONTINUED ON BACK)

MEDICAL HISTORY

Physician's name_____ Date of last visit_____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe_____

Have you been diagnosed with Osteoporosis? ☐ Yes ☐ No

Have you been treated with a bisphosphonate (Fosamax, Actonel, Reclast, etc.)? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

If the patient is a child, what is his/her weight?_____

Check (√) if you have had any of the following:

- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List any medications you are currently taking
(include over-the-counter pain reliever or allergy medication)

_____

_____

Pharmacy Name_____ Phone_____

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Ibuprofen/Advil
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. Stephanie Scheich or Dr. Jeff Scheich all 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I have also read and understand this office's HIPAA policies and guidelines.

Date_____ Signature _____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the

Name of minor/child

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.

Date_____ Signature _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date_____ Signature _____