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 ______________________________

SS/HIC/Patient ID # ______________________________

Patient Name ______________________________

Address ______________________________

City ______________________________

State ________________ Zip ____________

E-mail ______________________________

Sex ☐ M ☐ F Age ________ Birthdate ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced

Occupation ______________________________

Patient Employer/School ______________________________

Employer/School Address ______________________________

____

Employer/School Phone (_____) ______________________________

Spouse's Name ______________________________

Birthdate ________________ SS# ____________

Spouse's Employer ______________________________

Whom may we thank for referring you? ______________________________

DENTAL INSURANCE

Subscriber's Name ______________________________

Relationship to patient ______________________________

Birthdate ________________ SS# ____________

Insurance Co. ______________________________

Group #________________ Phone (____) ____________

Is patient covered by secondary insurance? ☐ Yes ☐ No

Subscriber's Name ______________________________

Relationship to Patient ______________________________

Birthdate ________________ SS# ____________

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

MEDICAL HISTORY

Physician's Name ______________________________ Date of last visit ________________

Phone (_____) ________________ Pharmacy ________________ Phone (_____) ________________

- over -

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

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

Have you ever had or been diagnosed with:

Condition	Yes	No
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:

Allergen	Yes	No
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 ________________________ (Name of Insurance Company(ies)) and assign directly to 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:______________________________