

Patient Information

Patient Name: _____ Date: _____

Gender(M/F): _____ Marital Status: _____ Birth Date: _____ Social Security #: _____

Driver's License Number: _____ Email Address: _____

Address: _____

Phone #'s: Home: _____ Work: _____ ext _____ Fax: _____

Pager: _____ Cell: _____ Other: _____

Referral Information

Name of person, office or other source that referred you to our practice: _____

Responsible Party Information

If responsible party is the patient, please check here skip this section and continue to employment information section

Name: _____ Date: _____

Gender(M/F): _____ Marital Status: _____ Birth Date: _____ Social Security #: _____

Driver's License Number: _____ Email Address: _____

Address: _____

Phone #'s: Home: _____ Work: _____ ext _____ Fax: _____

Pager: _____ Cell: _____ Other: _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address & Phone: _____

Insurance Information

Primary Insurance

Name of Insured: _____

Insured's Date of Birth: _____ ID#: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: Self Spouse Child Other

Insurance Company Name, Address & Phone: _____

Secondary Insurance (If Applicable)

Name of Insured: _____

Insured's Date of Birth: _____ ID#: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: Self Spouse Child Other

Insurance Company Name, Address and Phone: _____

Dental History

Reason for today's visit _____
 Former Dentist _____
 City/State _____
 Date of last dental visit _____

Date of last Full Mouth X-rays (if known) _____

Please check "yes" to indicate if you have, or had any of the following:

Bad breath Yes
 Bleeding Gums Yes
 Blisters on lips/mouth Yes

Cigarette, pipe, or cigar smoking Yes
 Clicking or popping jaw Yes
 Dental implants Yes
 Food collection between the teeth Yes
 Grinding teeth Yes
 Gums swollen, tender Yes
 Jaw pain or tiredness Yes
 Lip or cheek biting Yes
 Loose teeth Yes
 Broken fillings Yes
 Mouth breathing Yes
 Pain upon brushing Yes

Orthodontic treatment Yes
 Pain around ear Yes
 Periodontal treatment Yes
 Sensitivity to cold Yes
 Sensitivity to heat Yes
 Sensitivity to sweets Yes
 Sensitivity when biting Yes
 Sores or growths in your mouth Yes
 Teeth whitening Yes
 TMJ treatment, or pain Yes
 How often do you floss? _____
 How often do you brush? _____

Health History

Physician's Name, Address, and Phone: _____

Date of Last Visit: _____

Please check "yes" to indicate if have had any of the following:

AIDS/HIV Yes
 Allergies, list _____ Yes
 Anemia Yes
 Arthritis Yes
 Artificial Heart Valves Yes
 Artificial Joints Yes
 Asthma Yes
 Abnormal Bleeding Yes
 Bacterial Endocarditis Yes
 Blood Disease Yes
 Cancer Yes
 Chemical Dependency Yes
 Circulatory Problems Yes
 Cortisone Treatments Yes
 Diabetes Yes

Emphysema Yes
 Epilepsy Yes
 Fainting or Dizziness Yes
 Glaucoma Yes
 Headaches or Migraines Yes
 Heart Murmur Yes
 Heart Problems Yes
 Hepatitis, Type ____ Yes
 Herpes Yes
 High Blood Pressure Yes
 Hospitalized in past 5 years Yes
 Kidney Disease Yes
 Liver Disease Yes
 Mitral Valve Prolapse Yes
 Pacemaker Yes
 Psychiatric Care Yes

Radiation Treatment Yes
 Respiratory Disease Yes
 Rheumatic Fever Yes
 Sinus Trouble Yes
 Stroke Yes
 Thyroid Problems Yes
 Tuberculosis Yes
 Tumor or growth on head or neck Yes
 Ulcers or Digestive problems Yes
 Venereal Disease Yes
 Any other medical conditions. List: _____

Women: Are you pregnant? Yes Due date _____ Are you nursing? Yes
 Taking birth control pills? Yes

Medications

List any medications you are currently taking, and why you are taking it:

Pharmacy Name _____
 Phone _____

In Case of Emergency, Notify:

Name: _____ Relationship: _____

Phone: _____

Affirmation and Acknowledgement

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes.

I understand that I am financially responsible for all charges, whether or not paid by insurance. Past due accounts are subject to a 1.5% per month finance charge (18 % APR). If my account has to be sent to an attorney or collection agency, I will be responsible for all legal and collection fees incurred by this office.

Patient Signature

Date

Assignment and Release of Dental Insurance Benefits

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____, and assign directly to Dr. Jeffrey H. Schillinger 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. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with an insurance claim.

I authorize the use of this signature on all insurance submissions.

Patient Signature

Date

Thank you for filling out this form completely.

It will enable us to help you more effectively.

Payment is due in full at the time of treatment unless prior financial arrangements have been made.