SCHMITT DENTAL

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Patient Information:

Name _____ Birthdate _____ SSN: _____
Last First Middle MM/DD/YYYY

Address_____
Number and Street City/State Zip

Phone: _____/_____/_____
Home Work Cell

Employer: _____ Occupation: _____

Email: _____

☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced ☐ Child

Name of Spouse / Parent / Guardian: _____ Birthdate: ____/_____/_____ SSN: _____
Last First

How did you hear about us? ☐ Sign ☐ Directory ☐ Friend/Family- Name:_____
☐ Radio ☐ Other: _____

Responsible Party/ Military Sponsor If Applicable:

Name _____ Birthdate _____ SSN: _____
Last First Middle MM/DD/YYYY

Phone: _____/_____/_____
Home Work Cell

Employer: _____ Occupation: _____

MILITARY ONLY- Rank: _____ Duty Assignment: _____ Duty Phone #: _____

Insurance Information:

Dental Insurance: ☐ Yes ☐ No If Yes, Name of Company: _____ Group #: _____

Name of Insured / Sponsor: _____ SSN or ID #: _____
Last First

To avoid misunderstanding regarding dental insurance, we wish our patients to know that all services rendered are charged to the patient and that the patient is personally responsible for the fees. As a courtesy, we will assist you in preparing necessary forms and submit to your insurance company to help obtain your benefits from them. We do not render our services on the basis that your insurance company will pay the fee. ***ALL SERVICES RENDERED ARE CASH, CHECK, MASTERCARD, VISA, DISCOVER OR CARECREDIT, UNLESS OTHERWISE PREARRANGED***.
Our office operates on an appointment system. **If necessary for you to change an appointment, please give us 48 hour notice so that we may accommodate other patients**. If your appointment is failed without notice, a fee may be charged on a case by case basis for lost time we were unable to make available to another patient. We respect your time and will make every effort to treat you in a timely fashion. Occasionally an emergency may put us behind schedule. In such a situation we will keep you informed and present you with the option of rescheduling your appointment if necessary.

Please complete the Medical History and Consent for Treatment Form on the reverse side. Thank you.

Medical History: *(Answers are for our records ONLY and will be confidential)*

Are you under the care of a physician now? ☐ Yes ☐ No If Yes, Reason for care? _____

Name of Physician: _____ Date of Last Exam: _____/_____/_____

Circle any of the following if you have now or have ever had in the past: (circle all that apply)

AIDS	Heart Ailments Describe: _____	Neurological Problems
Anemia	Artificial Heart Valves	Psychiatric Care
Arthritis	By-Pass Surgery	Radiation Treatment
Artificial Joints	Cardiac Pacemaker	Rheumatic Fever
Asthma	Heart Murmur	Rheumatism
Blood Disease	Mitral Valve Prolapse	Seizures
Cancer	High Blood Pressure	Sinus Problems
Chemical Dependency	Hemophilia	Stroke
Chemotherapy	HIV Positive	Syphilis
Colitis	Gonorrhea	Thyroid
Diabetes	Infectious Hepatitis	Tonsillitis
Epilepsy	Kidney Disease	Tuberculosis
Eye Disorders	Liver Disease	Ulcer
Fainting Spells		Venereal Disease

Allergies:

Are you allergic to or have you reacted adversely to any of the following?

Local Injected Anesthetics: ☐ Yes ☐ No

Penicillin or other antibiotics: ☐ Yes ☐ No

Codeine or other narcotics: ☐ Yes ☐ No

Aspirin: ☐ Yes ☐ No

Hay fever or Allergies in general: ☐ Yes ☐ No

Excessive Bleeding from a cut or extraction: ☐ Yes ☐ No

Have you ever taken Fen-Phen: ☐ Yes ☐ No

Current Medications: *Prescribed and Over-the-Counter*

Are you taking any medications now? ☐ Yes ☐ No

If yes, please list the name and purpose of the medication:

_____ _____

_____ _____

Have you ever had any serious illness, operation or injury? ☐ Yes ☐ No

If yes, please describe: _____

Is there any information we should know about previous dental visits? _____

For Women: a. Are you pregnant or do you think you may be pregnant? ☐ Yes ☐ No If yes, Due Date: _____

b. Are you taking birth control pills? ☐ Yes ☐ No

Consent of Treatment:

The following information is not presented to worry you, but rather to conform to the principles of "Informed Consent". Any local injected anesthetic or oral surgical procedure may result in certain post-operative effects. Usually these effects are limited to discomfort, bleeding, swelling, and less frequently infection. On rare occasions, numbness of the lips, chin or tongue, prolonged healing, injury to other teeth, broken jaws, sinus openings, and injury to the ligaments of the jaw joint may occur. *The utmost care will be taken to minimize the possibility of these complications.*

Assignment and Release:

"I have read and understand the above explanation. This is to certify that I, the undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated." I assign all dental insurance benefits directly to Steven T. Schmitt, DMD. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize Steven T. Schmitt, DMD to release all information to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions.

Patient's Signature: _____ Date: _____

(Parent / Guardian Signature if patient is a minor) MM/DD/YYYY