

# Patient Information

M. Rene Schamp D.D.S.

Patient Name \_\_\_\_\_

Phone (C) \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Referred By \_\_\_\_\_ Family Physician \_\_\_\_\_

Employer Name & Address \_\_\_\_\_

Dental Insurance Yes \_\_\_ No \_\_\_ If yes, Insurance Company \_\_\_\_\_

Insurance Group Number \_\_\_\_\_ Ins Phone # \_\_\_\_\_

If other than Patient, Who is responsible for Insurance Coverage?

Spouse \_\_\_ Parent \_\_\_ Other \_\_\_

Responsible Person's Name & Address \_\_\_\_\_

Resp. Person's Employer & Address \_\_\_\_\_

Resp. Person's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Resp. Person's Social Security Number \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

In Case Of Emergency, Please notify: \_\_\_\_\_ Ph. # \_\_\_\_\_

## Consent for Services

As a condition of your treatment by this office, payment is due at time of service. This practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate provided for dental care shall only be valid for 6 months from the date the estimate is provided. I further acknowledge that any such estimate provided is not a guarantee of the cost of any services ultimately provided

In consideration for the professional services rendered to me at my request by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or her/his assignee, at the time said services are rendered, or within 5 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay reasonable attorney fees at all levels, including appeals incurred as a result of said breach whether or not suit is instituted.

I grant my permission to you and your assignee, to telephone me at my home or at my work to discuss matters related to this form or the services provided hereunder.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Signature of Patient, Parent, or Guardian

\_\_\_\_\_  
Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Signature of guarantor of payment/responsible party

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

Primary reason for this dental appointment:  Examination  Emergency  Consultation

**Dental History**

Please Circle

Do you have a specific dental problem? Describe \_\_\_\_\_ Yes No  
 Do you have dental examinations on a routine basis? Last visit \_\_\_\_\_ Yes No  
 Do you think you have active decay or gum disease? \_\_\_\_\_ Yes No  
 Do you brush and floss on a routine basis? Discuss \_\_\_\_\_ Yes No  
 Do your gums ever bleed? Discuss \_\_\_\_\_ Yes No  
 Do you like your smile? Why? \_\_\_\_\_ Yes No  
 Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ Yes No  
 Do you want to keep your remaining teeth? \_\_\_\_\_ Yes No  
 Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_ Yes No  
 Have your past experiences in a dental office always been positive? \_\_\_\_\_ Yes No  
 Do you smoke or chew? Any sores or growths in your mouth? Discuss \_\_\_\_\_ Yes No  
 Name of previous dentist (optional): \_\_\_\_\_  
 Date of last full mouth x-rays (16 small films or panoramic): \_\_\_\_\_

**Medical History**

Are you under a physician's care now? Why? \_\_\_\_\_ Who? \_\_\_\_\_ Phone \_\_\_\_\_ Yes No  
 Have you ever been hospitalized or had a major operation? Discuss \_\_\_\_\_ Yes No  
 Have you ever had a serious injury to your head or neck? Discuss \_\_\_\_\_ Yes No  
 Are you taking any medications, pills or drugs? What? \_\_\_\_\_ Ever taken fen-phen? \* \_\_\_\_\_ Yes No  
 Are you on a special diet? Discuss \_\_\_\_\_ Yes No  
 Are you allergic to any medications or substances? Please check box below \_\_\_\_\_ Yes No  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex Rubber  Other \_\_\_\_\_  
 Women (Please check):  Pregnant/trying to get pregnant  Nursing  Taking oral contraceptives Discuss \_\_\_\_\_ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.

\*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No			
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur *	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Treatments (Radiation)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Bleeding Problem)	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse *	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever *	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve *	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint *	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker *	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Medicines)	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Pollen / Dust)	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained Fever	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Tattoos	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes No

Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X \_\_\_\_\_ Date \_\_\_\_\_

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_

History Review and Significant Findings \_\_\_\_\_

**Medical Updates**

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	NONE	PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____