SCHROEDER CREEK DENTAL

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Birthdate _____/_____/_____ Soc. Sec. Number _____-____-_____ Marital Status _____

Home Phone # (_____) _____-_____ Sex _____

Employed by _____ Cell Phone _____

Spouse's Name _____ DOB _____ Soc. Sec. Number _____-____-_____

Employed by _____ Cell Phone _____

Is it ok to correspond with you through text? ◉ Y /N ○ Email address _____

Name of Medical Doctor _____ Phone _____

Who is financially responsible for this bill? _____

Whom may we thank for referring you to us? _____

Do you regularly smoke tobacco? _____ If yes, how much per day? _____

Do you regularly have tooth sensitivity? _____ Do you regularly have dry mouth? _____

Do you have a history of gum disease? _____

Have you ever had a problem associated with previous dental treatment? If yes, please elaborate _____

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY Of THE FOLLOWING:

	YES	NO		YES	NO
Heart Disease / Failure / Attack ……	☐	☐	Asthma ……	☐	☐
Angina Pectoris ……..	☐	☐	Bruise Easily ……..	☐	☐
Congenital Heart Disease ……..	☐	☐	Seasonal Allergies / Hives …….	☐	☐
Heart Murmur ……	☐	☐	Sinus Trouble …….	☐	☐
High Blood Pressure / Arteriosclerosis …….	☐	☐	Radiation Therapy / Chemotherapy ……..	☐	☐
Mitral Valve Prolapse ……	☐	☐	Hepatitis A (infectious) / B (serum)	☐	☐
Artificial Heart Valve / Pacemaker ……...	☐	☐			
Heart Surgery ……	☐	☐	A.I.D.S. / HIV positive	☐	☐
Rheumatic Fever ……..	☐	☐			
Arthritis / Rheumatism ……	☐	☐	Blood Transfusion ……..	☐	☐
Drug Addiction ……	☐	☐	Hemophilia / Anemia …….	☐	☐
Stroke ……	☐	☐	Sickle Cell Disease ……	☐	☐
Artificial Joints …….	☐	☐	Liver Disease	☐	☐
Kidney Trouble ……	☐	☐	Epilepsy or Seizures.....	☐	☐
Diabetes …….	☐	☐	Psychiatric Treatment.....	☐	☐
Thyroid Problems ……..	☐	☐	Allergy to Any Medications	☐	☐
Glaucoma ……	☐	☐	Please specify _____		
Emphysema ……	☐	☐	_____		
Chronic Gough ……	☐	☐	Current Medications ……..	☐	☐
Tuberculosis ……	☐	☐	Please specify _____		
			_____		

Is there anything you would like for us to know to help us care for you better? _____

_____

WOMEN: Are you pregnant or taking birth control pills?

To the best of my knowledge, all of the preceding answers are true. If I ever have a change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

The undersigned, hereby authorized the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature here authorizes my dentist to submit claims for benefits, services rendered, or to be rendered without obtaining my signature. This holds true for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ _____

Authorized Signature of Covered Person / Employee **Date**

_____ I ACKNOWLEDGE THAT I WILL BE PERSONALLY RESPONSIBLE FOR ANY AND ALL CHARGES NOT COVERED BY MY INSURANCE.