

*We are pleased to welcome you to our gentle and caring dental practice for adults & children.  
Please take a few minutes to fill out this form as completely as you can.  
If you have questions we'll be glad to help you.*

**Patient Information**

Date \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Soc. Security # \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ E-Mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Guardian

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified ? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Primary Insurance**

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered under this plan \_\_\_\_\_

**Additional Insurance**

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered under this plan \_\_\_\_\_

## Dental History

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Check (✓) if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Click or popping jaw          | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## Medical History

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Have you ever had any serious illness or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments                     | <input type="checkbox"/> Heart Problems        | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent                        | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood                           | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy                                 | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting                                 | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Family History of<br>periodontal disease | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Glaucoma                                 | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Headaches                                | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Murmur                             | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Circulatory Problems    |   | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                      |
|  |   | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease           |

### MEDICATIONS

List medications you are currently taking:

### ALLERGIES

\_\_\_\_\_  
\_\_\_\_\_  
*To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.*

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

## Authorization

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Dr. Michael Schodowski 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.

Dr. Michael Schodowski 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.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

**Payment is due in full at time of treatment unless prior arrangements have been approved.**