

## Rebecca A. Schmor, D.D.S.

General and Aesthetic Dentistry  
301 Glenwood Avenue, Suite 210  
Raleigh, NC. 27603 (919) 834-4450  
glenwoodsmiles.com

Dear new patient,

Welcome to our office. We sincerely appreciate your choosing us as your dental office and look forward to your becoming part of our family of patients. We understand you may be feeling a little apprehensive about today's visit, but don't worry, this is a very natural feeling. In order for us to put you at ease and to get to know you better, it is very important for you to answer the following questions accurately. Please take your time.

### PATIENT INFORMATION

Name \_\_\_\_\_ Social Security \_\_\_\_\_  
Last Name First Name Middle Initial

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

Sex  M  F Marital Status:  Single  Married  Widowed Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Work Phone \_\_\_\_\_

In case of emergency, whom should we contact? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Former dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

Check the appropriate box if you have, or have had, any of the following:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Bad breath or unpleasant taste | <input type="checkbox"/> Food collecting in teeth       | <input type="checkbox"/> Periodontal treatment      |
| <input type="checkbox"/> Bleeding Gums                  | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot or cold |
| <input type="checkbox"/> Blisters on lips or mouth      | <input type="checkbox"/> Gums swollen or tender         | <input type="checkbox"/> Sensitivity to sweet       |
| <input type="checkbox"/> Burning sensation on tongue    | <input type="checkbox"/> Jaw pain or tiredness          | <input type="checkbox"/> Sensitivity to biting      |
| <input type="checkbox"/> Chew on one side of mouth      | <input type="checkbox"/> Lip or cheek biting            | <input type="checkbox"/> Sores or growths in mouth  |
| <input type="checkbox"/> Tobacco smoking                | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Pain/blood when flossing   |
| <input type="checkbox"/> Tobacco chewing                | <input type="checkbox"/> Mouth breathing                | <input type="checkbox"/> Clicking or popping jaw    |
| <input type="checkbox"/> Dry mouth                      | <input type="checkbox"/> Pain around ear                | <input type="checkbox"/> Orthodontic treatment      |

Do you drink bottled or tap water? \_\_\_\_\_ How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

Do you like the shape of your teeth? \_\_\_\_\_ Are there fillings or caps you don't like \_\_\_\_\_

Do you like your smile? \_\_\_\_\_ If not, why not? \_\_\_\_\_

# MEDICAL HISTORY

Physician's name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illnesses or operations? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_\_ If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_ Taking birth control pills? \_\_\_\_\_

Check the appropriate box if you have or have had any of the following:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Nervous problems      |
| <input type="checkbox"/> Arthritis, rheumatism   | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Pacemaker             |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Radiation treatment   |
| <input type="checkbox"/> Artificial joints       | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Respiratory treatment |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatic fever       |
| <input type="checkbox"/> Back problems           | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Scarlet fever         |
| <input type="checkbox"/> Blood disease           | (Describe) _____                             | <input type="checkbox"/> Skin rash             |
| <input type="checkbox"/> Cancer                  | _____  | <input type="checkbox"/> Shortness of breath   |
| <input type="checkbox"/> Chemical dependency     | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Sickle cell disease   |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Circulatory problems    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problems      |
| <input type="checkbox"/> Cortisone treatment     | <input type="checkbox"/> HIV positive        | <input type="checkbox"/> Tonsillitis           |
| <input type="checkbox"/> Cough, persistent       | <input type="checkbox"/> Jaw pain            | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Coughing up blood       | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Ulcer                 |

# MEDICATIONS

List medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy you use? \_\_\_\_\_

Phone number? \_\_\_\_\_

Are you allergic to:

- Aspirin  
 Codeine  
 Local anesthetic  
 Penicillin  
 Sulfa  
 Other \_\_\_\_\_

Use the space below to describe any other health condition that may have a bearing on your dental treatment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## INSURANCE INFORMATION

We cannot accept insurance reimbursement as a form of payment; however, as a courtesy, we will complete insurance forms and provide necessary documentation so that you may easily file with your insurance provider.

Person responsible for account \_\_\_\_\_

Relation to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Phone \_\_\_\_\_

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

Responsible person employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance company \_\_\_\_\_

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

## CONSENT AND RELEASE

I consent to the dental procedures and anesthetics that are considered necessary for the proposed treatment including any intraoral and/or extraoral photographs. I also permit the release of any information to or from my physician as may be required. I also agree to assume full financial responsibility for all the dental treatment needed.

\_\_\_\_\_  
Signature of patient/responsible party

\_\_\_\_\_  
Date

## PROFESSIONAL POLICY

**To Our Patients:** Our mission is to deliver the highest quality dentistry to our patients in the kindest, most gentle manner possible. Quality means using the best materials on the market, employing the latest technology available to dentistry as well as staying current through continuing education courses.

**Insurance:** We do not accept insurance as a form of payment; however, we will give you a completed insurance form for you to mail to your insurance company at the end of your visit. We will gladly forward any narratives, x-rays, intraoral pictures, treatment plan estimates or any other pertinent information requested from your insurance company.

**Financial Agreement:** We accept personal checks, Visa, Mastercard, and Discover. In addition, we offer a 90-day same-as-cash payment plan, a six or twelve month interest free payment plan through Wells Fargo Financial, for patients who qualify. For patients with extensive treatment plans we also work with the DFP company which is an organization specifically designated to financing dental treatment.

**Wells Fargo Agreement:** Wells Fargo Financial offers a 90-day same as cash option which is extremely popular with our patients with dental insurance. There is generally a 30-day turn around time for insurance reimbursements for patients and this plan offers them an opportunity to be reimbursed before payment is due. Wells Fargo also offers a six-month or twelve-month payment plan for patients needing extensive dental treatment. They will finance \$1,000 or less for a period of six months. During that time a minimum monthly payment is required; however, your first payment will not be due until 59 days after your appointment. There is a 5% processing fee associated with this plan. Wells Fargo also offers a twelve-month payment plan for treatment plans over \$1,000. There is a 10% processing fee for the twelve-month plan. If you are interested in any of these plans, please ask our front desk person for an application. After the application has been completed it will be faxed and an answer should be returned within an hour.

**Dental Fee Plan:** DFP affords our patients with treatment plans of over \$1,500 an opportunity to finance their work with low interest rates as well as an extended period of time in which to repay the loan. Please ask our front desk person for more information regarding this plan. DFP may be contacted by telephone or you may visit their website.

**Dental X-Rays:** Patients who have not had oral x-rays taken within the past two years will be required to have a new series of x-rays. Current oral x-rays are essential in order to allow Dr. Schmorrr to diagnose certain types of oral cancer, cysts, decay not visible in the mouth, possible infections (abscess) of root tips, gum disease, and to determine the general health of the teeth.

**Appointments:** In order to provide quality dentistry in a timely manner, we try not to schedule two patients at the same time. Therefore, it is critical that if you must reschedule or cancel an appointment you do so at least 48 hours in advance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_