Schwartz Family Dentistry Adult Patient Information

Name_____ **Date of Birth**____/____/____

Address_____ **Home Phone**_____

City_____ **State**____ **Zip**_____ **Cell Phone**_____

Email_____ **Work Phone** _____

Social Security Number_____ **Preferred Method of Contact**_____

Spouse/ Partner Information

Name_____ **Date of Birth**____/____/____

Address_____ **Home Phone**_____

City_____ **State**____ **Zip**_____ **Cell Phone**_____

Email_____ **Work Phone** _____

Social Security Number_____

Dental Insurance Information

Primary Dental Insurance_____ **ID#**_____

Subscriber Name_____ **DOB**_____

Employer_____ **Group #**_____

Secondary Dental Insurance_____ **ID#**_____

Subscriber Name_____ **DOB**_____

Employer_____ **Group #**_____

Emergency Contact

Name_____ **Relationship**_____

Phone #_____

Who may we thank for referring you? _____

Office Policies:

-You are responsible for payment in full at the time services are rendered.
-We accept cash, checks, Visa, Mastercard and Discover credit cards.
-There is a $30.00 NSF Service Fee for all returned checks.
-We offer payment plans to fit your budget. All payment plans must be agreed upon prior to the date of service. Please call the office manager to discuss these options.
- If your account balance becomes 60 days past due, and you have not contacted our office regarding the past due amount, the amount will be charged to your credit card or begin to accrue interest on your account at 18% APR-
- We set aside time for our patients by scheduling appontments. If an appointment is cancelled without adequate notice or broken without notice at all, it prevents others from scheduling appointments. If an appointment is cancelled without at least 24 hours notice, or broken without a 24 hour notice, a missed appointment fee of $50 will be charged to your account at our discretion. You may call our office to cancel an appointment 24 hours a day, seven days a week.

Signature_____ Date_____

Patient Medical History

Patient Name: _____

Primary Care Physician: _____ Phone# _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have and important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

		If yes, please explain
Are you under a physicians care now other than routine ?	O Yes O No	
Please list any medications, pills, or drugs you are taking ?	O Yes O No	
Are you under a cardiologist's care? If YES, please provide the name and phone number of doctor.	O Yes O No	
Are you taking any over the counter/herbal supplements ?	O Yes O No	
Have you ever had a total joint replacement ?	O Yes O No	
Do you have any known allergies ?	O Yes O No	
What is the name and phone number of your preferred pharmacy ?	O Yes O No	
Are you currently on a blood thinner ?	O Yes O No	
Have you ever taken bone density medications containing bisphosphonates ? (Fosaman, Boniva, Actone)?	O Yes O No	

Women: Are you... ○ Pregnant/Trying to get Pregnant ? ○ Nursing ? ○ Taking oral contraceptives?

AIDS/HIV Positive	O Yes O No	Diabetes Type 1	O Yes O No	Hepatitis B	O Yes O No	Osteoporosis	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes Type 2	O Yes O No	Hepatitis C	O Yes O No	Pain in Joints	O Yes O No
Anemia	O Yes O No	Drug Addiction	O Yes O No	High Blood Pressure	O Yes O No	Parathyroid Disease	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Cholesterol	O Yes O No	Psychiatric Care	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Hives/Rash	O Yes O No	Radiation Treatments	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Irregular Heartbeat	O Yes O No	Renal Disease	O Yes O No
Blood Disease	O Yes O No	Fainting/Dizzy Spells	O Yes O No	Kidney Problems	O Yes O No	Rheumatism	O Yes O No
Blood Transfusion	O Yes O No	Hearing Impairment	O Yes O No	Leukemia	O Yes O No	Sinus Trouble	O Yes O No
Breathing Problems	O Yes O No	Hear Attack/Failure	O Yes O No	Liver Disease	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Cancer	O Yes O No	Heart Murmur	O Yes O No	Low Blood Pressure	O Yes O No	Stroke	O Yes O No
Chemotherapy	O Yes O No	Heart Pacemaker	O Yes O No	Lung Disease	O Yes O No	Swelling of Limbs	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Trouble/Disease	O Yes O No	Memory Loss	O Yes O No	Thyroid Disease	O Yes O No
Congenital Heart Disorder	O Yes O No	Hemophilia	O Yes O No	Mitral Valve Prolapsed	O Yes O No	Tuberculosis	O Yes O No
Convulsions	O Yes O No	Hepatitis A	O Yes O No				

Have you ever had any serious illness not listed above ? O Yes O No **If yes, please explain** _____

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Comments: _____

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To the best of my knowledge, the questions on this form have been accurately answered, I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform he dental office of any changes in medical status.

Signature of Patient, Parent or Guardian"

Signature X _____ Date: _____