Schwartz Family Dentistry Patient Information Up to 18 Years Old

Name______________________________ **Date of Birth**____/____/____

Address______________________________ **Home Phone**______________

City______________ **State**____ **Zip**________ **Cell Phone**______________

Guardian Information:

Mother's Name______________________ **Contact Phone**______________

Date of Birth____/____/____

Address (if different than above)______________________________

Father's Name______________________ **Contact Phone**______________

Date of Birth____/____/____

Address (if different than above)______________________________

Legal Guardian's Name ______________________ **Contact Phone**______________

Address (if different than above) ______________________________

Patient Resides with _______**both parents**_______ **mother only**_______ **father only**_______ **legal guardian**

Dental Insurance Information:

Primary Dental Insurance______________________ **ID#**______________

Subscriber Name______________________ **DOB**______________

Employer______________________ **Group #**______________

Secondary Dental Insurance______________________ **ID#**______________

Subscriber Name______________________ **DOB**______________

Employer______________________ **Group #**______________

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 apponitments. 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.

Question		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... O Pregnant/Trying to get Pregnant ? O Nursing ? O Taking oral contraceptives?

Condition		Condition		Condition		Condition	
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** ____________

Comments: ____________

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: ____________