

ADVANCED DENTAL SYSTEMS

DAVID SCHADE, D.D.S. AND ASSOC.

Patient Information

Please Print

Date: _____

Name: _____
First Middle Initial Last

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: M ___ F ___ Birth Date: _____ e-mail: _____

Marital Status: M ___ S ___ Name of Spouse: _____

Person to notify in case of emergency: _____ Phone #: _____

Employer (University / School if Student): _____

Whom may we thank for referring you? _____

If patient is a minor, responsible parents name: _____

Insurance Information

Dental Insurance Carrier: _____ Phone #: _____

Policyholder(name): _____ Policyholder's Phone #: _____

Policyholder I.D. # (or SSN): _____

Policyholder's Date of Birth: _____ Group or Plan #: _____

Relationship to policyholder (Check): Self Spouse Dependent Other _____

Dental History

Former Dentist: _____

Reason for today's visit: _____

Date of last exam: _____ Date of last dental x-rays: _____

Please check any of the following conditions that apply to you:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot/cold/sweet |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Broken fillings |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Previous Orthodontic work |

(Continue on back)

Office Policies

Please read, initial each section, and sign below.

_____ **PAYMENT:** Payment in full is expected at the time services are rendered. We accept cash, checks, MasterCard, VISA, Discover, and CareCredit. A returned check fee of \$30.00 will be assessed for any check payment that is returned due to insufficient funds. Subsequently, payment options for patients or accounts with returned items may be limited to cash or credit card.

_____ **DENTAL INSURANCE:** If we agree to accept assignment of benefits from a dental insurance company, patients must pay for any portion of the charges not covered as services are rendered. If payment for any dental claim is not received within 45 days, you will receive a statement for the entire balance due. If payment is not made within 45 days of receipt of the statement, your account may be turned over to collections. Charges that are denied or not covered by the insurance company are the responsibility of the patient or guardian.

_____ **COLLECTION COSTS:** Account balances more than 45 days past due may be sent to collections. Patients will be responsible for costs of collections including, but not limited to, collection agency fees, attorney fees and court costs.

_____ **PATIENT AND INSURANCE INFORMATION:** The patient will be responsible for informing the office of any changes to the following: mailing address, phone numbers, emergency contact information, insurance plan information, and changes in medical history, including the list of medications you are currently taking.

_____ **BROKEN APPOINTMENTS:** A missed appointment or late cancellation charge of \$25/hour will be assessed for any appointment that is missed, or for any appointment that is cancelled with less than 24 hours notice.

_____ **HIPAA:** I have reviewed and/or received a copy of the office's Notice of Privacy Practices.

_____ **QUESTIONS:** Open communication is an important part of ongoing treatment and is essential if we are to keep you well informed and happy with our services. If you have any questions regarding your bill or dental treatment, please ask for clarification or additional information.

By signing below, I acknowledge that I have read, understood, and agree to the above office policies. I also understand that I am ultimately financially responsible for any balance on my account.

Signature: _____ Date: _____

Medical History

Name: _____ Date: _____

Primary Care Physician (medical): _____ Phone #: _____

Please list all medications you are currently taking:

1) _____

2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____

8) _____ 9) _____ 10) _____

Allergies to medications: _____

Allergy to latex: Yes No

(Women) Are you pregnant? Yes Due Date: _____ No Nursing? Yes No

Are you taking birth control pills/hormone replacement therapy? Yes No

Please check if you have ever or now have any of the following:

AIDS / HIV	Circulatory Problems	Hemophilia	Respiratory Disease
Anemia	Cortisone Treatments	Hepatitis A / B (circle)	COPD
Arthritis, Rheumatism	Congenital Heart Disease	Hepatitis C	Emphysema
Artificial Heart Valve	Cough - persistent, or	Herpes	Shortness of Breath
Artificial Joint (circle)	with blood	High Blood Pressure	Stroke
Knee / Hip	Diabetes	Immunosuppressive Drugs	Chemical Dependency
Other: _____	(Family Hist. - diabetes)	Infective Endocarditis	Swelling of feet/ankles
Asthma	Epilepsy / Seizures	Intestinal Disorder	Thyroid Problems
Auto Immune Illness	Fainting/Dizziness	Kidney Disease	Tobacco Habit
Back Problems	Glaucoma	Dialysis	Tuberculosis
Blood Disease	Heart Attack	Kidney Transplant	Ulcers
Cancer	Heart Problems:	Liver Disease	Venereal Disease
Chemotherapy	_____	Nervous Problems	Psychiatric Care
Radiation Treatment	Heart Surgery	Pace Maker	Headaches (chronic)
Surgery	Heart Transplant	Parkinson's	Bisphosphonate Medication (for bones)

Please list any other medical conditions or hospitalizations that we should be aware of: _____

Are you under the care of a specialist for any of these conditions? Yes No

Name of Specialist (If 'yes'): _____ Phone: _____

To the best of my knowledge, all of the preceding information provided is true and complete. If I ever have any change in my health, I will inform the doctors at the next appointment.

Signature of patient, parent or guardian _____ Date: _____