PATIENT NAME **HEALTH HISTORY DATE**

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 an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
Are you under a physician's care now? If so, please list your doctor's information and your pharmacy	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you suffer from migraines? If so, are you taking any medication for them?	Yes No	If yes
Do you have sleep apnea?	Yes No	If yes
Do you wear contact lenses?	☐	
Do you suffer from acid reflux?	☐	
Have you been hospitalized within the last 5 years? If so, please explain.	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances? Yes No If yes

Other? ☐ If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed Yes No If yes

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 the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:__________

Welcome To The Office of Dr. James Schmidt & Associates

DATE: ____________________ **PLEASE PRINT CLEARLY**

Patient Name: (Last)____________________ (First)____________________ (Initial)_____

Birthdate: (M/D/Y)____________________ Age: _______ Gender: Male Female

Social Security #:____________________

Address: ____________________ Apt/Unit:________

City:____________________ State: ____________________ Zip: ____________

Phone: (Home)____________________ (Work)____________________ (Cell)____________________

Email:____________________ Employer: ____________________

If patient is a minor, Parent / Guardian Name: ____________________

Do you have Dental Insurance? (circle) YES NO

If yes, who is the Insurance Subscriber? (circle) Self / Spouse / Parent / Guardian

Subscribers Name: ____________________ Birthdate: ______________ SOC#____________________

Subscribers Employer:____________________

Please provide a copy of your insurance card, and/or fill out our separate "Insurance Information" form

IN CASE OF AN EMERGENCY:

Medical Doctor Name:____________________ Phone:____________________

Emergency Contact Name: ____________________ Phone:____________________ Relationship:__________

AUTHORIZATION:

I authorize my insurance company to assign benefit payments directly to this dental office.
I authorize the release of my records to third party payers, other healthcare professionals, or entities deemed necessary by this office for the sole purpose of providing me with the most comprehensive treatment possible.
I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by my insurance, as well as any additional collection costs that may incur as a result of my treatment.
I have reviewed the information on this form and deem it accurate to the best of my knowledge.

I have read this office's *"Notice of Privacy Practices"* and can request a copy at any time.

Signature:____________________________________ Date:____________________

Patient or Responsible Party

Date: ________________

DENTAL HISTORY

Patient Name: ____ Age: ____________

1. Date of last dental visit? ___/___/___ Date of last dental x-rays? ___/___/___
2. Reason for seeking care today? ____
3. Do you snore or have Sleep Apnea? (circle) Yes No
4. Do your gums bleed? (circle) Yes No
5. Are your teeth loose? (circle) Yes No
6. Have you been told you have Gum Disease? (circle) Yes No
7. Do you have concerns about bad breath or a bad taste in your mouth? (circle) Yes No
8. Are your teeth sensitive? (circle all that apply) Sweets Cold Hot Chewing Biting
9. Have you ever had any pain, clicking or popping in your jaw joints? (circle) Yes No
10. Do you clench or grind your teeth? (circle) Yes No
11. Are you happy with your smile? (circle) Yes No
    If no, please explain: ____
12. What would you change about the present condition of your mouth? ____________________
    ____
13. Are you anxious about dental treatment? (circle) Yes No
14. Do you have any concerns about previous dental care or this dental visit? ____________________
    ____
15. Comments: ____

To the best of my knowledge, the answers I have given are accurate. I understand it is important to report any changes or updates in my medical and dental status. I give permission to obtain from my physician any additional information regarding my medical history that may be needed in order to provide me with the best treatment possible.

Patient Signature: ______________________________ **Date:** ________________

If you have completed this form for another person, please print your name and sign below along with your relationship to the patient.

Print: ______________________________ **Signature:** ______________________________

Relationship: ______________________________ **Date:** ______________________________

INSURANCE INFORMANTION

DATE: ____________________

PATIENT NAME: ____ DOB: __________________

PRIMARY DENTAL INSURANCE

RELATIONSHIP TO SUBSCRIBER: _____________________________

SUBSCRIBER NAME: ____ DOB: __________________

SUBSCRIBER SSN: ____

SUBSCRIBER EMPLOYER: ____

NAME OF DENTAL INSURANCE: ____

ID #: ____________________________________ GROUP #: _______________________________

DENTAL INSURANCE ADDRESS: ____

____

INSURANCE PH #: __________________________ INSURANCE FAX #: ______________________

SECONDARY DENTAL INSURANCE

RELATIONSHIP TO SUBSCRIBER: _____________________________

SUBSCRIBER NAME: ____ DOB: __________________

SUBSCRIBER SSN: ____

SUBSCRIBER EMPLOYER: ____

NAME OF DENTAL INSURANCE: ____

ID #: ____________________________________ GROUP #: _______________________________

DENTAL INSURANCE ADDRESS: ____

____

INSURANCE PH #: __________________________ INSURANCE FAX #: ______________________

Dental Insurance & Patient Responsibility Policy

While we do our best to verify dental benefits as a courtesy to our patients, this does not guarantee insurance coverage or payments to Family & Cosmetic Dentistry.

A patient's insurance policy is a contract between the patient and the insurance company.

It is the patient's responsibility to know their insurance coverage and benefit limits of the policy before entering into any treatment.

Insurance is designed to assist the patient in their financial obligation to our office. The patient is receiving their dental service as they requested and is responsible for all charges on the account. This also applies to any family members on their policy.

If you have dental insurance, we will file your claim to your dental insurance provider, as a complimentary service. It is very important that you update our office with any changes in your policy or personal information.

I acknowledge having read this form. By signing below, I understand and agree to the terms and conditions.

____

Signature Date

Exam & Xray Consent

I give consent to the dentist to complete a dental examination and take any xrays deemed necessary to aid in my thorough diagnosis.

____

Signature Date

James L. Schmidt, D.D.S PC

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, financial agreement or your financial responsibility.

PLEASE INITIAL EACH LINE TO EXPRESS YOUR UNDERSTANDING:

1. _____Our practice requires 48 hours advance notice for appointment cancellations. If a patient fails to give advance notice or does not show for their scheduled appointment, a $50.00 fee will be charged to the patient's account for each appointment hour missed.

2. _____Your insurance is your responsibility. It is your responsibility to call your dental insurance prior to treatment to find out your deductible, maximum, percentages, limitations and exclusions. We can only estimate your portion or what your insurance will pay by the information provided to us.

3.______You are ultimately responsible for all charges not covered by your dental insurance company.

4.______By contract with your insurance company, we MUST collect your carrier designated deductible and percentage or co-pay. This payment will be collected at the time of service.

5.______Self Pay-Patients will be required to pay in full at the time of service unless other financial arrangements have been made prior to the appointment.

6.______Non-payment of outstanding balances at 90 days will be forwarded to a third party for collections.

NO ADDITIONAL CONTACT WILL BE MADE BY OUR OFFICE AT THAT POINT.

I HAVE READ AND UNDERSTAND THE PRACTICE'S FINANCIAL AGREEMENT AND AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE PERIODICALLY AMENDED BY THE PRACTICE.

____

PRINT PATIENT NAME PATIENT SIGNATURE DATE

____

SIGNATURE OF AUTHORIZED PERSON RELATIONSHIP TO PATIENT DATE

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

DR. JAMES SCHMIDT & ASSOCIATES

YOU MAY CHOOSE NOT TO SIGN THIS ACKNOWLEDGEMENT

I have read and/or received a copy of this office's Notice Of Privacy Practices.

Print Name: ____

Signature: ____

Date: ____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt or that the patient has read our Notice of Privacy Practices. Acknowledgement could not be obtained due to the following reason:

____ Individual chose not to sign.

____ Communications barrier prohibited obtaining the acknowledgement.

____ An emergency prevented us from obtaining the acknowledgement.

____ Other (please specify)

____

____

____

Family & Cosmetic Dentistry
7809 Watson Road
St. Louis, MO 63119
314-968-7979

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. Authorization to speak with family/friend (including spouse)

I, ____________________________,give the following named person(s) authorization to take messages or speak with the office of Family & Cosmetic Dentistry, on my behalf regarding (please check all items authorized):

Name of authorized person(s):______________________________________
Relationship ___________________ Phone number ___________________
Appointments __ Financial __ Dental Treatment __ Insurance _____
Other (explain) ____

Name of authorized person(s):______________________________________
Relationship ___________________ Phone number ___________________
Appointments __ Financial __ Dental Treatment __ Insurance _____
Other (explain) ____

Name of authorized person(s):______________________________________
Relationship ___________________ Phone number ___________________
Appointments __ Financial __ Dental Treatment __ Insurance _____
Other (explain) ____

Authorization to Leave Health Information by Alternate Means.
I authorize the doctors and staff of Family & Cosmetic Dentistry to use the following telephone numbers provided on the Patient Registration Form to leave messages on voice mail for reminder calls and other patient matters.

____________________________Home Phone
____________________________Work Phone
____________________________Cell Phone

____________________________________ Signature ________________ Date