New Patient Checklist

To help you prepare for your first visit, we have created a list of items you will want to bring to your reserved appointment time above:

_______ This packet of information with all paperwork completed

________Your insurance card

_______ Your valid driver's license or state ID

_______ A list of current medications (if the space provided on the Medical History isn't adequate)

_______ Your records and x-rays from your previous dental health provider (if possible)

TIME 12:58 PM DATE 6/28/2017

PATIENT REGISTRATION

ID: ______ Chart ID: ______

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ______

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: ______ Address 2: ______

City: ______ State / Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ______ Age: ______ Soc Sec: ______ Drivers Lic: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: ______ Pref. Dentist: ______

Employer ID: ______ Pref. Pharmacy: ______

Carrier ID: ______ Pref. Hyg: ______

Section 3

Emergency Contact ______

Primary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City, State, Zip: ______ City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

Secondary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City, State, Zip: ______ City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

Question	Answer	If yes
Are you under a physician's care now?	◯ 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 use controlled substances?	◯ 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

Other? ☐ If yes

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

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
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 above? ◯ 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:___________

DENTAL HISTORY

Name: ______________________________

Referred by ______________________________ Previous dentist: ______________________________

How would you rate the current condition of your mouth? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Date of most recent dental exam: ___/___/___ Date of most recent x-rays: ___/___/___

Date of most recent treatment (other than a cleaning) ___/___/___

I routinely see my dentist every: [ ] 3 mo [ ] 4 mo [ ] 6 mo [ ] 12 mo [ ] Not routinely

What is your immediate concern? ______________________________

PLEASE ANSWSER YES OR NO TO THE FOLLOWING: Yes No

PERSONAL HISTORY

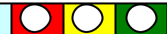
#	Question	Yes	No
1.	Are you fearful of dental treatment: How fearful, on a scale of 1 (least) to 10 (most) [____]		
2.	Have you had an unfavorable dental experience?		
3.	Have you ever had complications from past dental treatment?		
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?		
5.	Did you ever have braces, orthodontic treatment orhad your bite adjusted?		
6.	Have you had any teeth removed?		
7.	Have you avoided regular dental care? If so, why? ____		
8.	Are you currently being treated for breathing or sleep problems (i.e. sleep apnea, snoring, sinus)		

GUM AND BONE

9. How often do you brush?___________ Floss?___________ Use other aides? ____________

#	Question	Yes	No
10.	Do your gums bleed or are they painful when brushing or flossing?		
11.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?		
12.	Have you ever noticed an unpleasant taste or odor in your mouth?		
13.	Is there anyone with a history of periodontal disease in your family?		
14.	Have you ever experienced gum recession?		
15.	Have you ever had any teeth become loose on their own (without an injury)? Difficulty eating an apple?		
16.	Have you experienced a burning sensation in your mouth?		

TOOTH STRUCTURE



#	Question	Yes	No
17.	Have you had any cavities within the past 3 years?		
18.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?		
19.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?		
20.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?		
21.	Do you have grooves or notches on your teeth near the gum line?		
22.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?		
23.	Do you frequently get food caught between any teeth?		

BITE AND JAW JOINT

#	Question	Yes	No
24.	Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?		
25.	Do you feel like your lower jaw is being pushed back when you bite your teeth together?		
26.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars or other hard/dry food?		
27.	Have your teeth changed in the last 5 years, become shorter, thinner or worn?		
28.	Are your teeth becoming more crooked, crowded or overlapped?		
29.	Are your teeth developing spaces or becoming more loose?		
30.	Do you have more than one bite, squeeze, or have to shift your jaw to make your teeth fit together?		
31.	Do you place your tongue between your teeth or close your teeth against your tongue?		
32.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		
33.	Do you clench your teeth in the daytime or make them sore?		
34.	Do you have any problems with sleep (i.e. restlessness), wake up with a headache or awareness of your teeth?		
35.	Do you wear or have you ever worn a bite appliance?		

SMILE CHARACTERISTICS

#	Question	Yes	No
36.	Is there anything about the appearance of your teeth that you would like to change?		
37.	Have you ever whitened (bleached) your teeth?		
38.	Have you felt uncomfortable or self conscious about the appearance of your teeth?		
39.	Have you been disappointed with the appearance of previous dental work?		

Patient's Signature ______________________________ Date ____________

Doctor's Signature ______________________________ Date ____________

Schaefer Dental
HAPPY PEOPLE, HEALTHY SMILES

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances.

- Medical emergencies
- In situation required by law
- Individuals involved in your care
- When requested by a public health agency
- When requested by a law enforcement agency

For any purposes other than treatment, obtaining payment, healthcare operations or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.*
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.*
- Your have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

**Conditions and limitations may apply; obtain addition information from a team member.*

Changes To This Notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an update notice will be posted and a copy will be sent to you.

Schaefer Dental
HAPPY PEOPLE, HEALTHY SMILES

Financial Policy

Thank you for choosing Schaefer Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as easy and manageable for our patients as possible by offering some payment options.

Payment options

1. We accept cash, personal check, Visa, MasterCard, American Express, or Discover.

2. EZ Pay - this option is for people that would like to break their co-pay into a few payments. With this option, you prepay for your services. Convenient payments can be scheduled for days and amounts of your choosing with an automatic charge to a debit or credit card. Once you have your treatment plan paid in full, you can schedule your appointment and won't have the worry of financial arrangements at your reserved time.

3. CareCredit - this option is for people that need work done immediately but still need to be able to make payments over an extended period of time. This option is available after credit approval, as it is a medical credit card. Interest-free loans are available for amounts over $200 (see plan details for more information).

We require payment in full at the beginning of your treatment, at the time of service. We no longer bill for services or offer in-house financing.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. * The estimated co-pay and deductible for the treatment rendered must be paid in full on the date of service. Please understand that we can only estimate your out-of-pocket expense based on the information we receive from your insurance carrier and that you are ultimately responsible for all fees generated by your treatment.

We request that a 48-hour notice is given if you are unable to keep your appointment. A $50 fee may be applied to accounts for multiple missed appointments.

Returned checks will incur a $35 charge, plus any fees from the bank. Accounts sent to collections will incur a $50 fee. Charges such as this must be paid before any further appointments may be made.

*If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Rev. 06/17

Acknowledgement of Receipt of the "Notice of Privacy Practices"

This document acknowledges that you have received a copy of the "Notice of Privacy Practices" from David A Schaefer DDS LLC. This document is not a contract, authorization, release or consent form, and is to remain in your records.

X ____

Patient's Signature or Parent/Legal Guardian's Signature if patient is a minor or under the care of a relative, friend or caregiver — Date

Acknowledgement of Receipt of the "Financial Policy"

This document acknowledges that you have received a copy of the "Financial Policy" from David A Schaefer DDS LLC. My signature signifies that I understand the financial policies of this practice and will be prepared to work within them as stated.

X ____

Patient's Signature or Parent/Legal Guardian's Signature if patient is a minor or under the care of a relative, friend or caregiver — Date

Consent to share information

I give David A Schaefer DDS LLC permission to discuss my treatment and financial information with the following. I understand that without your permission, they cannot discuss <u>any</u> information with my spouse, family members, etc.

____

____

____

Media Release Consent information

I consent that David A Schaefer DDS LLC may use photographs or videos of me, taken during my dental visits, on their social media tools which includes but is not limited to their website and Facebook page. I understand that these images and/or videos will not be used for any other commercial purposes without my written permission.

Name (please print)**:**______________________________________

Signature:______________________________________

Date:____________________

Minor Consent:

***If parent is signing for a Minor:** ______________________________

(please print minor's name)