SCHROCK DENTAL LLC

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Schrock Dental
Patient Health History

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

SSN: _____

Primary Insurance

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insured's Birthdate: _____

Name of Employer:

Secondary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Whom may we thank for referring you?

_____

_____

Emergency Contact. Please enter name and telephone number below:

_____

_____

Dental History

Are you satisfied with the appearance of your teeth? ◯ Yes ◯ No

_____

_____

Are you nervous about dental treatment? ◯ Yes ◯ No

If yes, please explain

_____

_____

Do either of your parents have gum disease or wear dentures? ◯ Yes ◯ No

Have you ever had any of the following Periodontal Treatments or Oral Surgery?

☐ Root Planing (deep cleaning) ☐ Gum Grafting ☐ Gum Surgery ☐ Dental Implants

☐ Tooth Extraction(s)

If yes, please explain

_____

_____

Check if any of the following apply:

☐ Bad taste or odor in your mouth

☐ Sensitive teeth

☐ Loose teeth

☐ TMJ problems/ TMD / Pain in jaw

☐ Clenching or grinding your teeth

☐ Have you been advised or do you wear a night guard

☐ Trauma or injury to the mouth

☐ Did you have Braces

☐ OTHER not mentioned

☐ Have you ever had prolonged bleeding following a tooth extraction, a cut, or an injury?

If yes, please explain

_____

_____

_____

Medical History

Are you currently under the care of a physician for a medical condition? ◯ Yes ◯ No

If yes, please explain

_____

_____

Have you had any serious illness, operation, or been hospitalized? ◯ Yes ◯ No

Do you smoke or use tobacco products? * ◯ Yes ◯ No

Have you taken Bisphosphonates or any Bone Strengthening Medicines for Osteoporosis or Osteopenia? * ◯ Yes ◯ No

Have you ever had a joint replacement? ◯ Yes ◯ No

If yes, which joint(s) and date of surgery:

Have you seen a physician for any Heart related problems?

- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Heart Valve Condition/Replacement
- ☐ Rheumatic Fever
- ☐ Heart Surgery; including Stent Placement
- ☐ Heart Attack(s)
- ☐ Chest Pain or Angina
- ☐ Congenital Heart Defect
- ☐ Irregular Heart Rate
- ☐ Cardiac Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure

If yes, please explain

Are you Allergic to or have had a reaction to the following?

- ☐ Local Anesthetics (novocaine)
- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Latex
- ☐ Iodine
- ☐ Tape

If yes, Please explain

_____

_____

_____

_____

Are you allergic to any other medications or drugs not listed above? ◯ Yes ◯ No

If yes, please list medications you are allergic to:

_____

_____

_____

_____

List all Medications, Herbal Remedies, and Vitamins you currently take:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Women: Are you

☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Using birth control

NOTE: Antibiotics and some pain medications after the effectiveness of birth control pills. Consult your Physician or Gynecologist for assistance regarding additinal methods of birth control.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

☐ *Pre-Med	☐ Allergies	☐ Allergy - Aspirin	☐ Allergy - Codeine
☐ Allergy - Hay Fever	☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin
☐ Allergy - Sulfa	☐ Allergy Anesthetics	☐ Allergy Metals	☐ Anemia
☐ Arthritis/Gout	☐ Artificial Hrt Valve	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Chemo/Radiation	☐ Chest Pains
☐ Cold Sores	☐ Congenital Hrt Issue	☐ Diabetes	☐ Epilepsy/Seizures
☐ Excessive Bleeding	☐ Fainting/dizziness	☐ Glaucoma	☐ Head Aches
☐ Heart Attack	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ HIV/AIDS	☐ Hypoglycemia	☐ Kidney Problems
☐ Leukemia	☐ Liver Disease	☐ Low Blood Pressure	☐ Lung Disease
☐ Mental Disorders	☐ Mitral Valve Issues	☐ Osteoporosis	☐ Other
☐ Pacemaker	☐ Pain in Jaw Joint	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Substance Abuse	☐ Thyroid Conditions	☐ Tobacco use	☐ Tuberculosis
☐ Tumors/Growths	☐ Ulcers	☐ Venereal Disease	

Have you ever had any other serious illness not stated above or something that is listed above that needs more explanation?

_____

_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ *

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I am responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice cannot and does not assume any responsibility for my use or misuse of patient information or other information transmitted, monitored, stored, uploaded, or received using the site or the services.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Insurance Information:
As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year.
All of our doctors will diagnose treatment based on your dental health and not your insurance coverage.

Response Date: _____