

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

If yes, please explain

- Are you under a physicians care now other than routine ?       Yes  No \_\_\_\_\_
- Please list any medications, pills, or drugs you are taking ?       Yes  No \_\_\_\_\_
- Are you under a cardiologist's care?  
If YES, please provide the name and phone number of doctor.       Yes  No \_\_\_\_\_
- Are you taking any over the counter/herbal supplements ?       Yes  No \_\_\_\_\_
- Have you ever had a total joint replacement ?       Yes  No \_\_\_\_\_
- Do you have any known allergies ?       Yes  No \_\_\_\_\_
- What is the name and phone number of your preferred pharmacy ?       Yes  No \_\_\_\_\_
- Are you currently on a blood thinner ?       Yes  No \_\_\_\_\_
- Have you ever taken bone density medications containing bisphosphonates ? (Fosaman, Boniva, Actone)?       Yes  No \_\_\_\_\_

Women: Are you...       Pregnant/Trying to get Pregnant ?       Nursing ?       Taking oral contraceptives?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Diabetes Type 1	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes Type 2	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis C	<input type="radio"/> Yes <input type="radio"/> No	Pain in Joints	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hives/Rash	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Renal Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Fainting/Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Hear Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Memory Loss	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapsed	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No				

Have you ever had any serious illness not listed above ?  Yes  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 the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian"

Signature X \_\_\_\_\_

Date: \_\_\_\_\_