SCHNEIDER FAMILY DENTISTRY, S.C.

190 Gardner Ave. Suite 5
Burlington, WI 53105
Tel. (262) 763-6921

WE WOULD LIKE TO GET TO KNOW YOU BETTER!

NAME ______________________________

RESIDENCE ______________________________

______________________________ ZIP __________

HOME PHONE ______________________________

DATE OF BIRTH ______________________________

DRIVER'S LIC. # ______________________________

SOCIAL SECURITY # ______________________________

E-MAIL ADDRESS ______________________________

IF STUDENT, NAME OF SCHOOL/COLLEGE

____

OCCUPATION ______________________________

EMPLOYER ______________________________

EMPLOYER'S ADDRESS ______________________________

______________________________ ZIP __________

EMPLOYER'S PHONE ______________________________

SPOUSE'S OCCUPATION ______________________________

SPOUSE'S EMPLOYER ______________________________

EMPLOYER'S ADDRESS ______________________________

______________________________ ZIP __________

EMPLOYER'S PHONE ______________________________

WHOM MAY WE SEND A THANK YOU FOR YOUR REFERRAL

____

PERSON RESPONSIBLE FOR DENTAL INVESTMENT

____

FINANCIAL ARRANGEMENTS -
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

- ❑ Cash
- ❑ Dentamed
- ❑ Personal Check
- ❑ Credit Card
- ❑ Visa
- ❑ Mastercard

DATE ______________________________

FOR INSURANCE PURPOSES:

NAME OF PRIMARY CARRIER:

____

____

INSURED ______________________________

INSURED'S BIRTHDATE ______________________________

INSURED ID # ______________________________

GROUP/POLICY # ______________________________

EFFECTIVE DATE ______________________________

NAME OF SECONDARY CARRIER:

____

____

INSURED ______________________________

INSURED'S BIRTHDATE ______________________________

INSURED ID # ______________________________

GROUP/POLICY # ______________________________

EFFECTIVE DATE ______________________________

LATE CHARGES -
If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

AUTHORIZATION AND RELEASE -
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such health care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or medical group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ______________________________
Signature of patient (or parent if minor)

MEDICAL & DENTAL INFORMATION

	YES	NO
Are your teeth sensitive to		
Heat?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting Pressure?	☐	☐
Do your gums bleed when brushing?	☐	☐
Have you noticed any gum swelling around any teeth?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Are you dissatisfied with your teeth and their appearance?	☐	☐
Do you want to learn to control dental disease and retain your teeth?	☐	☐
Do your have any unpleasant taste or odor in your mouth?	☐	☐
Do you smoke or use tobacco?	☐	☐
Have you ever had any teeth removed?	☐	☐

When?______________________________

	YES	NO
Do you feel you will eventually wear dentures?	☐	☐
Do you have any allergies?	☐	☐

Allergic to: ____________________________________

	YES	NO
Have you had frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
When was your last dental appointment?	☐	☐

Why did you leave your last dentist? ______________

____

What is your present dental problem?______________

____

Physician____Office Phone___________________Date of Last Exam__________________

	YES	NO
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐

If yes, please explain ______________________________

____

	YES	NO
Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medication(s) are you taking______________

____

____

____

____

____

	YES	NO
Have you ever taken Phen-Fen/Redux?	☐	☐
Do you have or have you had any heart trouble?	☐	☐
Do you use controlled substances?	☐	☐
Are you wearing contact lenses?	☐	☐
Have you ever been told by a physician that you need to be pre-medicated?	☐	☐

If so, with what? ________________________________

____

Women Only:

	YES	NO
a) Are you pregnant, think you may be pregnant or nursing?	☐	☐
b) Are you taking oral contraceptives?	☐	☐

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

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Thyroid Problem	☐	☐	Sexually Transmitted Disease	☐	☐
Rheumatic Fever	☐	☐	Cardiac Pacemaker	☐	☐	Stomach Troubles /Ulcers	☐	☐
Swollen Ankles	☐	☐	Heart Murmur	☐	☐	Easily Winded	☐	☐
Fainting / Seizures	☐	☐	Angina	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Frequently Tired	☐	☐	Hay Fever / Allergies	☐	☐
Low Blood Pressure	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐
Epilepsy / Convulsions	☐	☐	Emphysema	☐	☐	Radiation Therapy	☐	☐
Leukemia	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Arthritis	☐	☐	Recent Weight Loss	☐	☐
Kidney Disease	☐	☐	Joint Replacement or Implant	☐	☐	Liver Disease	☐	☐
AIDS or HIV Infection	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
						Other	☐	☐

DATE	UPDATE	INITIALS
/ /	NC / C:	-
/ /	NC / C:	-
/ /	NC / C:	-
/ /	NC / C:	-
/ /	NC / C:	-
/ /	NC / C:	-
/ /	NC / C:	-