Schnierow
DENTAL CARE

Patient Information Sheet

Chart # _____

Patient Information

First Name:_____ Int.:_____ Last Name:_____ Date of Birth:____/____/____

Home Address:_____ Apt. #:_____ City:_____ State:_____ Zip:_____

Work Phone #: ( ) _____ Home Phone #: ( ) _____

Cell Phone #: ( ) _____ E-mail Address: _____

DL #:_____ Social Security #:_____-_____-_____ Sex: (M) (F)

Employer:_____ Position:_____

Employer Address:_____ Employer Phone #: ( )_____

In Case of Emergency, contact: (name)_____ Phone Number: ( )_____

Name of Physician:_____

Address:_____ City:_____ Telephone: ( )_____

Address:_____ City:_____ Telephone: ( )_____

How Did You Hear About Us?

☐ Flyer/Ad ☐ Insurance/Plan Referral ☐ Sign/Bldg Location ☐ Marketing Representative

☐ Yellow Pages ☐ Employer ☐ Other DDS Referral ☐ Family/Friend ☐ Website

☐ Community Event: _____ ☐ School: _____ ☐ Other: _____

Responsible Party
(Disregard if same as above)

First Name:_____ Int.:_____ Last Name:_____ Date of Birth:____/____/____

Home Address:_____ Apt. #:_____ City:_____ State:_____ Zip:_____

Home Phone #: ( )_____

DL #:_____ Social Security #:_____-_____-_____ Sex: (M) (F)

Employer:_____ Position:_____ How Long?_____

Work Address:_____

Work Phone Number: ( )_____ Ext. _____ Department:_____

Primary Insurance Information

Insured First Name:_____ Last Name:_____ Date of Birth:____/____/____

Insured Address:_____

Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured Social Security # : _____-_____-_____

Employer Name & Phone Number:_____ Insurance Company:_____

Insurance Co. Address:_____ Effective Date:_____

Group #:_____ Policy #:_____ Phone Number of Insurance Co.: ( )_____

Secondary Insurance Information

Insured First Name:_____ Last Name:_____ Date of Birth:____/____/____

Insured Address:_____

Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured Social Security # : _____-_____-_____

Employer Name & Phone Number:_____ Insurance Company:_____

Insurance Co. Address:_____ Effective Date:_____

Group #:_____ Policy #:_____ Phone Number of Insurance Co.: ( )_____

I request that all dental benefits, if any, otherwise payable to me for services rendered to be paid to the provider of service. I understand that I am financially responsible for all charges if insurance proceeds are insufficient to cover my obligations and/or a procedure. I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctor's assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services.
I am aware that by signing below I certify that all information is complete and correct. Burton D. Schnierow D.D.S., Inc., may verify this information from whichever sources it deems necessary (including, but not limited to, credit reports) and may provide others with information regarding my credit history (or the credit report) to the extent permitted by law. This is my authorization for Burton D. Schnierow D.D.S., Inc., to verify credit history.

Signature of Patient _____ Signature of Responsible Party _____

Health Questionnaire

These questions are for your benefit and assure that treatment will take into consideration your past and present health status.
Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? ..... **Yes** **No**

MEDICAL HISTORY

Are you in good health? ..... **Yes** **No**
Date of last physical examination _____
Are you under the care of a physician? ..... **Yes** **No**
If so, what is the condition being treated? _____
Have you ever had any serious illness or operation? ..... **Yes** **No**
If so, what illness or operation? _____
Have you ever been hospitalized? ..... **Yes** **No**
If so, what was the problem? _____
Are you taking any ☐ medications ☐ drugs or ☐ herbs? ..... **Yes** **No**
If so, what? _____ What dosage? _____
Are you using any recreational drugs (marijuana, cocaine, etc.)? ☐ Yes ☐ No If so, what? _____
Have you ever been premedicated with antibiotics for your dental treatment? ..... **Yes** **No**
Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Latex ☐ Other
If other, what drugs? _____
Do you have or have you had any of the following: (Please circle **Y** for Yes and **N** for No – answer all conditions):

Y N Anemia	**Y N** Hay Fever	**Y N** Head Injuries	**Y N** Cerebral Palsy	**Y N** Rheumatic Fever	**Y N** Sickle Cell Disease	**Y N** Psychiatric Treatment
Y N Herpes	**Y N** Glaucoma	**Y N** Heart Failure	**Y N** Drug Addiction	**Y N** Tuberculosis (T.B.)	**Y N** Cortisone Medicine	**Y N** Hepatitis or Jaundice
Y N Stroke	**Y N** Tonsillitis	**Y N** Scarlet Fever	**Y N** Kidney Disease	**Y N** Blood Transfusion	**Y N** Allergies to Metals	**Y N** Difficulty Swallowing
Y N Ulcers	**Y N** Hemophilia	**Y N** Sinus Trouble	**Y N** Chemotherapy	**Y N** Joint Replacement	**Y N** Excessive Bleeding	**Y N** Congenital Heart Lesions
Y N Diabetes	**Y N** Cold Sores	**Y N** Heart Murmur	**Y N** Stomach Ulcers	**Y N** Nervous Disorders	**Y N** Mitral Valve Prolapse	**Y N** X-Ray or Cobalt Treatment
Y N Arthritis	**Y N** Emphysema	**Y N** Liver Disease	**Y N** Angina Pectoris	**Y N** Tumors or Growths	**Y N** High Blood Pressure	**Y N** Radiation Treatment of any kind
Y N Asthma	**Y N** Rheumatism	**Y N** Blood Disease	**Y N** Mental Disorder	**Y N** Allergies or Hives	**Y N** HIV Related Complex	**Y N** Venereal Disease (Syphilis, Gonorrhea)
Y N Cancer	**Y N** Chicken Pox	**Y N** Heart Ailments	**Y N** Thyroid Disease	**Y N** Pain in Jaw Joints	**Y N** Respiratory Disease	**Y N** Acquired Immune Deficiency Syndrome (AIDS)
Y N Seizures	**Y N** Bruise Easily	**Y N** Heart Attack	**Y N** Fainting Spells	**Y N** Artificial Prosthesis	**Y N** Epilepsy or Seizures	**Y N** TMJ (Temporomandibular Joint) Disorder

Do you have any disease, condition or problem not listed that you think we should know about? ..... **Yes** **No**
Do you wear a cardiac pacemaker, or have you had heart surgery? ..... **Yes** **No**
Do you smoke? If yes, how much? _____ ☐ Cigarettes ☐ Cigars ☐ Packs per day ..... **Yes** **No**
Have you ever taken the drugs ☐ Phen Phen ☐ Redux or any ☐ diet drugs? ..... **Yes** **No**
(Women) Are you pregnant? If so, how many months? _____ ..... **Yes** **No**
(Women) Do you have any problems associated with your menstrual period? ..... **Yes** **No**
(Women) Do you take any birth control medication or hormones? ..... **Yes** **No**

DENTAL HISTORY

Have you ever had a local anesthetic (Novocaine, etc.)? ..... **Yes** **No**
Have you ever had any unfavorable reaction from a local anesthetic? ..... **Yes** **No**
Have you had any serious trouble associated with any previous dental treatment? ..... **Yes** **No**
If so, explain? _____
How long since your last full mouth X-Rays? _____ Weeks _____ Months _____ Years
How long since your last dental treatment? _____ Weeks _____ Months _____ Years
Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely? ..... **Yes** **No**
Would you desire to be pre-sedated? ..... **Yes** **No**

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

A **Date** _____ **Signature** _____

B **UPDATE – Since your last visit:**
Have you seen a medical doctor? ..... **Yes** **No**
Have you had a change in your medication? ..... **Yes** **No**
Have you had a change in your medical condition or had surgery? ..... **Yes** **No**
Please note changes in health since last visit. If no changes, please write "None"

Date _____ Signature _____

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Have you seen a medical doctor? ..... **Yes** **No**
Have you had a change in your medication? ..... **Yes** **No**
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Date _____ Signature _____

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Please note changes in health since last visit. If no changes, please write "None"

Date _____ Signature _____

Signed: _____ ***Date:*** _____ ***Relationship to Patient*** _____