PATIENT NFORMATION

Last Name: _____ First: _____ Middle: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____
(and Street if P.O. Box)

Home Phone: _____ Cell Phone: _____

GENDER M F	Date of Birth Mo. Day Yr.	Marital Status S M W D	Weight	Height

Occupation: _____ Employer's Name: _____

Employer's Address: _____ Business Phone: _____

Social Security No.: _____ Driver's License No.: _____

SPOUSE OR PARENT NFORMATION

Name: _____ Home Phone: _____ Business Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____
(and Street if P.O. Box)

Relationship to Patient: _____ Occupation: _____ Date of Birth: _____

Social Security No.: _____ Driver's License No.: _____

PAYMENTS TO BE MADE BY

Cash: _____ Check: _____ Master Card No.: _____ Visa Card No.: _____

DENTAL INSURANCE

Insured Party: _____ Policy No.: _____ Social Security No.: _____

Employer: _____ Insurance Company: _____

Send Claims To: _____

OTHER

Previous Dentist Name: _____ *Physician's Name:* _____

Name and Address of Nearest Living Relative: _____

Is any other member of your family a patient here? If so, Patient's Name: _____

Whom may we contact in case of emergency?: _____ Phone No.: _____

HOW DID YOU FIND ABOUT US? *(Please circle No.)*

1 Referred by a patient. Who? _____ 4 Yellow Pages

2 Referred by one of our Employees. Who? _____ 3 Saw our Office or Signs

5 Your Employer belongs to Preferred Patients Program

PLEASE, READ BELOW AND SIGN

In order to reduce confusion and misunderstanding between our patients and this practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office administrator. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either yourself or your dental coverage carroer, full payment for office services are due at the time of the service. For your convenience, we will accept VISA, Master Card, Discover and American Express Cards. We also offer a Care Credit (Financial Lender) as a means of payment.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the dentist--in other words, you agree to have your insurance company pay the dentist directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.

We have made prior arrangements with many insurers and other dental plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement and will only require you to pay the copayment at the time of service. We will collect the copayment when you arrive for your appointment.

If you have insurance coverage with a plan with whom we do not have prior agreement, we will prepare and send the claim for you on an unassigned basis. This mean your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of the service.

Dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Signature of Patient or Responsible Party if a Minor *Date*

AUTHORIZATION TO PAY PROVIDER: I hereby authorize my insurance company to pay Dr. Schwartz directly all dental and surgical benefits, to which I am entitled. I understand that I am fully responsible for any and all fees not covered by my insurance company. I hereby authorize said assignee to release all information necessary to secure payment.

Signed: _____

Should this account become delinquent and warrant collection/legal action, I the patient, assume all costs of collection, including but not limited to court costs, interests and legal fees.

Signed: _____

AUTHORIZATION TO RENDER CARE: I hereby authorize Dr. Schwartz to examine me or my child and render all services deemed necessary.

Signed: _____

NAME

REF. BY

DATE

MEDICAL HISTORY

Physician's Name: _____ Last Appt.: _____ Phone: _____

Are you pregnant?: Yes ___ No ___ If yes, anticipated delivery date: _____

Do you wear contact lenses?: Yes ___ No ___

Please check a definite answer for each question:

Yes ___ No ___ Any change in your health in the past two years?

Yes ___ No ___ Are you currently under the care of a physician? If yes, describe your treatment _____

Yes ___ No ___ Have you had any medical treatment or physician visit of any kind in the last two years? If yes, describe _____

Yes ___ No ___ *Have you had any surgical operation of any kind? If yes, describe* _____

Yes ___ No ___ Were you transfused at that time?

Yes ___ No ___ Have you been advised by a physician of the need for any surgery or treatment? For what? _____

Do you have, or have you ever been treated for any of the following?:

Yes ___ No ___ Allergy	Yes ___ No ___ Mental Disorder	Yes ___ No ___ Heart Problems
Yes ___ No ___ Arthritis	Yes ___ No ___ AIDS or HIV	Yes ___ No ___ Heart Murmur
Yes ___ No ___ Chronic Sinusitis	Yes ___ No ___ Tuberculosis	Yes ___ No ___ Mitral Valve Prolapse
Yes ___ No ___ Glaucoma	Yes ___ No ___ Diabetes	Yes ___ No ___ Valve Replacement
Yes ___ No ___ Thyroid Condition	Yes ___ No ___ Epilepsy, Seizures	Yes ___ No ___ Low Blood Pressure
Yes ___ No ___ Anemia, Sickle Cell Disease	Yes ___ No ___ Prolonged Bleeding	Yes ___ No ___ High Blood Pressure
Yes ___ No ___ Fainting	Yes ___ No ___ GI Problems	Yes ___ No ___ Pacemaker Type
Yes ___ No ___ Radiation/Chem. Therapy	Yes ___ No ___ Kidney Disorder	Yes ___ No ___ Shortness of Breath
Yes ___ No ___ Enzyme Deficiency	Yes ___ No ___ Hepatitis	Yes ___ No ___ Rheumatic Fever
Yes ___ No ___ Asthma	Yes ___ No ___ Ulcers	Yes ___ No ___ Hip or Joint Replaced
Yes ___ No ___ Chem./Alcohol Dependent	Yes ___ No ___ Anorexia, Bulimia	Yes ___ No ___ Venereal/Herpes II

Yes ___ No ___ Have you ever had an allergic reaction or been told not to take any medication? If yes, describe _____

Yes ___ No ___ Are you currently taking any prescription drugs of any kind (ex: birth control, hormone, diet)? If yes, what? _____

Yes ___ No ___ Are you currently taking any non-prescription drugs?

Yes ___ No ___ Do you use any tobacco products? If yes, daily intake: _____

DENTAL HISTORY

Yes ___ No ___ Are you aware of any dental problems at this time?

When was your last dental visit? _____ *What was performed?* _____

Yes ___ No ___ Are you seen in a dental office on a regular basis?

Yes ___ No ___ Do you experience pain or clicking in your jaw, ear, or facial muscles upon opening your mouth?

Yes ___ No ___ Do your gums bleed?

Yes ___ No ___ Do you suffer anxiety or gagging during dental procedures?

Yes ___ No ___ Are you unhappy with the appearance of your teeth? If so, why? _____

Have you had any of the following treatments?

Yes ___ No ___ Orthodontics. If yes, specify _____

Yes ___ No ___ Endodontics (Root Canal). If yes, specify _____

Yes ___ No ___ Periodontics (Gum Therapy). If yes, specify _____

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____

		TREATMENT PLAN	FEE
SOFT TISSUE EXAM			
CHEEKS			
SAL GLANDS			
FLOOR MOUTH			
PALATE			
THROAT			
TONGUE			
GINGIVA			
COLOR			
POCKETS			
BLEEDING			
FRENUM			
LIPS			
LYMPH NODES			
TMJ			
HARD TISSUE EXAM			
PLAQUE			
CALCULUS			
STAINING			
CON PERM/REM APPL			
BLOOD PRESSURE			
OTHER			