



Patient Registration

Please complete the following confidential information.

Date _____
Name of Patient _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Married _____ Divorced _____ Single _____ Widowed _____
Social Security Number _____ E-mail _____

Dental Insurance

Primary Carrier

Insurance Company _____ Group Number _____
Employee Name _____ Employer _____
Employee Social Security Number _____ Employee Date of Birth _____

Secondary Carrier

Insurance Company _____ Group Number _____
Employee Name _____ Employer _____
Employee Social Security Number _____ Employee Date of Birth _____

Person Responsible for Account

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

Is another member of your family or relative a patient at our office? _____
Name _____ Relationship _____

There is no better compliment than the referral of family, friends and co-workers.

Who may we thank for your referral? _____

Consent Form

- _____ 1. I hereby authorize Dr. Schmidt or designated staff to take X-rays, study photographs and any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of (name of patient)_____’s dental needs. I authorize the use of the radiographs, photographs or videotape of my case for presentations or publications of Dr. Schmidt.
- _____ 2. Upon such diagnosis, I authorize Dr. Schmidt to perform all recommended treatment mutually agreed upon by the doctor and myself, and to employ such assistance as required to provide proper care.
- _____ 3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- _____ 4. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.
- _____ 5. I authorize Dr. Schmidt to file my insurance and to collect payments directly from the insurance company on my behalf.

Patient Name _____ Date _____

Signature of Responsible Party _____

Relationship to Patient _____

For parents of children only

I understand that it is necessary for Dr. Schmidt to be able to completely focus on my child without distraction. Therefore, I may not be allowed in the treatment room during treatment.

Signature of Parent or Responsible Party _____

Medical History

Patient Name _____

Address _____ City _____ State _____ Zip _____

Home Telephone # _____ Work # _____ Cell # _____ e-mail _____

Emergency Contact _____ Telephone # _____

1. Have you been under the care of a medical doctor during the past two years?.....Yes No

If yes, for what? _____

Physician's Name _____ Telephone # _____

2. Have you taken any medication or drugs within the past two years?.....Yes No

3. Are you currently taking any medication or drugs?.....Yes No

If yes, please list _____

4. **Are you aware of having an allergic (or adverse reaction) to any medication or substance?**Yes No

If yes, please list _____

5. Have you been a patient in the hospital during the past five years?.....Yes No

6. **Have you ever used the prescription diet medication Pondimin, Redux or fen-phen?.....**Yes No

7. Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers.....	Yes	No	Venereal Disease.....	Yes	No
Chest Pain.....	Yes	No	Diabetes	Yes	No	H.I.V. Positive.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
Heart Murmur	Yes	No	Glaucoma.....	Yes	No	Blood Transfusion.....	Yes	No
High Blood Pressure.....	Yes	No	Emphysema.....	Yes	No	Hemophilia.....	Yes	No
Mitral Valve Prolapse	Yes	No	Chronic Cough.....	Yes	No	Sickle Cell Disease.....	Yes	No
Artificial Heart Valve	Yes	No	Tuberculosis.....	Yes	No	Bruise Easily.....	Yes	No
Heart Pacemaker.....	Yes	No	Asthma.....	Yes	No	Liver Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Hay Fever.....	Yes	No	Jaundice.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Latex Sensitivity/Allergy..	Yes	No	Neurological Disorders.....	Yes	No
Cortisone Medicine.....	Yes	No	Allergies or Hives.....	Yes	No	Epilepsy/Seizures.....	Yes	No
Swollen Ankles.....	Yes	No	Sinus Trouble.....	Yes	No	Fainting/Dizzy Spells.....	Yes	No
Stroke.....	Yes	No	Radiation Therapy.....	Yes	No	Nervousness/Anxiety.....	Yes	No
Diet (Special/Restricted).....	Yes	No	Chemotherapy.....	Yes	No	Psychiatric/Psychological Care.	Yes	No
Artificial Joints (hip, knee, etc.)..	Yes	No	Tumors.....	Yes	No	Tobacco Use.....	Yes	No
Kidney Trouble.....	Yes	No	Hepatitis A, B or C.....	Yes	No	Alcohol/Drug Abuse.....	Yes	No

8. Have you lost or gained more than 10 pounds in the past year?.....Yes No

9. Do you have or have you had any disease, condition or problem not listed above?.....Yes No

10. **Women**, are you: Pregnant? Yes _____ Months No Nursing? Yes No Taking birth control pills? Yes No

Doctor's Notes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the above questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Dental History

Welcome! So that we may provide you with the best possible care, please complete these forms. All information is kept confidential.

Patient Name _____

What is the reason for your visit today? _____

Date of last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ City _____ State _____ Zip _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (toothpick, proxabrushes, etc...) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

<p>Are any of your teeth sensitive to:</p> <p style="padding-left: 40px;">Hot or Cold? Yes No</p> <p style="padding-left: 40px;">Sweets? Yes No</p> <p style="padding-left: 40px;">Biting or Chewing? Yes No</p> <p>Have you noticed any mouth odors or bad tastes? Yes No</p> <p>Do you frequently get cold sores, blisters or any other oral lesions? Yes No</p> <p style="padding-left: 40px;">Do your gums bleed or hurt? Yes No</p> <p>Have your parents experienced gum disease or tooth loss? Yes No</p> <p>Have you noticed any loose teeth or change in your bite? Yes No</p> <p>Does food tend to become caught in between your teeth? Yes No</p> <p style="padding-left: 40px;">If yes, where? _____</p> <p style="padding-left: 40px;">Do you:</p> <p>Clench or grind teeth while awake or asleep? Yes No</p> <p style="padding-left: 40px;">Bite your lips or cheeks regularly? Yes No</p> <p style="padding-left: 40px;">Hold foreign objects with your teeth? (such as pencils, pipe, nails, fingernails) Yes No</p> <p style="padding-left: 40px;">Mouth breath while awake or asleep? Yes No</p> <p>Have tired jaws, especially in the morning? Yes No</p> <p style="padding-left: 40px;">Smoke/chew tobacco? Yes No</p>	<p>Have you ever had:</p> <p style="padding-left: 40px;">Orthodontic treatment? Yes No</p> <p style="padding-left: 40px;">Oral Surgery? Yes No</p> <p style="padding-left: 40px;">Periodontal treatment? Yes No</p> <p style="padding-left: 40px;">Your teeth ground or bite adjusted? Yes No</p> <p style="padding-left: 40px;">A bite plate or mouth guard? Yes No</p> <p style="padding-left: 40px;">A serious injury to the mouth or head? Yes No</p> <p style="padding-left: 40px;">If so, please describe, including cause _____</p> <p style="padding-left: 40px;">Have you experienced:</p> <p style="padding-left: 40px;">Clicking or popping of the jaw? Yes No</p> <p style="padding-left: 40px;">Pain in joint, ear or side of face? Yes No</p> <p style="padding-left: 40px;">Difficulty in opening or closing the mouth? Yes No</p> <p style="padding-left: 40px;">Difficulty in chewing on either side of the mouth? Yes No</p> <p style="padding-left: 40px;">Headaches, neckaches or shoulder aches? Yes No</p> <p style="padding-left: 40px;">Sore muscles in the neck or shoulders? Yes No</p> <p style="padding-left: 40px;">Are you satisfied with your teeth's appearance? Yes No</p> <p style="padding-left: 40px;">Would you like to keep all of your teeth all your life? Yes No</p> <p style="padding-left: 40px;">Do you feel nervous about having dental treatment? Yes No</p> <p style="padding-left: 40px;">If so, what is your biggest concern? _____</p> <p style="padding-left: 40px;">_____</p> <p style="padding-left: 40px;">Have you ever had an upsetting dental experience? Yes No</p> <p style="padding-left: 40px;">If yes, please describe _____</p> <p style="padding-left: 40px;">_____</p>
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Is there anything else about having dental treatment that you would like us to know?
 If yes, please describe _____



Financial Policy

Our goal is to help you achieve optimal dental care. We are pleased to offer you the following payment options to assist you in attaining optimal dental health.

- **Payment in full at first visit** with cash, check or credit card. We offer a courtesy adjustment for payment in full when you receive major dental treatment.
- **No or low interest-payment plans** with no down payment necessary in most cases. At no charge, we will gladly process any insurance claim.
- **Payment by appointment** with cash, check or credit card.
- **Estimated co-payment at visit** with cash, check or credit card with most insurance plans following benefit verification.
- When receiving a crown, payment of half of the total at the 1st appointment and payment of the remaining balance when the crown is delivered.

Please be aware that we cannot guarantee this estimate and that there may be a balance after insurance pays. **Rarely does an insurance company cover 100% of your dental treatment.** We will do our best to estimate your deductible and insurance portion of your dental plan. **However, any remaining balance is your direct responsibility.** This includes any non-covered services, yearly deductible and/or co-payments for your particular insurance plan. After a balance is 90 days past due, a service charge may be added to the account each month until the balance is paid in full.

To honor time reserved for our patients, we reserve the right to charge a fee for cancelled or missed appointments without 24 hours notice.

Signature of Patient or Guardian

Date



Lance R. Schmidt, D.D.S.

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may provide you with a report of your progress for your Insurance company, if applicable.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may use your information to contact you, for example, we may provide you with appointment reminders such as postcards, e-mails, texts, and/or a phone call. If you are not home, we may leave this information on your answering machine or with the person who answers the phone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal use.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- If this practice is sold, your information will become the property of the new owner.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- ACKNOWLEDGEMENT: (Please note: You may refuse to sign this acknowledgement)
- You have a right to receive a copy of this notice. Date _____

Signed _____ Print Name _____
If a signing as a parent or guardian, please note the name of patient _____
Thank you, and if you have any questions about this form or the Privacy Practices, please contact our privacy officer.

OFFICE USE ONLY: As privacy officer, I attempted to obtain the patient's (or representative's signature on the Acknowledgement but did not because ____ It was emergency treatment, ____ I could not communicate with the patient, ____ The patient refused to sign, ____ The patient was unable to sign because _____.

Signature of Privacy Officer _____