

RICHARD C. SCHMIDT, D.M.D., P.C.
BLAIR TUDOR, D.M.D.

PATIENT'S NAME _____
Last First Initial

Date of Birth _____ Male Female

IF CHILD:
PARENT'S NAME _____
Last First Initial

SOCIAL SECURITY # _____

DENTAL INSURANCE 1st COVERAGE

HOW DO YOU WISH TO BE ADDRESSED _____
 Single Married Divorced Widowed

EMPLOYEE NAME _____

EMPLOYEE ADDRESS _____

MAILING ADDRESS _____

EMPLOYEE BIRTH DATE _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____

RESIDENCE ADDRESS _____

INSURANCE COMPANY _____

CITY _____ STATE _____ ZIP _____

INSURANCE ADDRESS _____

PHONE #: RES _____ BUS _____

INSURANCE PHONE# _____

CELL # _____ E-MAIL _____

GROUP/POLICY# _____

AVAILABLE FOR SHORT NOTICE: YES NO

SOCIAL SECURITY# _____

BEST TIME TO CONTACT _____

PERSON RESPONSIBLE FOR ACCOUNT _____

PATIENT/PARENT EMPLOYED BY _____

NAME _____

PRESENT POSITION _____

ADDRESS (if different from above) _____

SPOUSE/PARENT NAME _____

PHONE #: RES _____ BUS _____

SPOUSE PARENT EMPLOYED BY _____

EMPLOYER _____

PRESENT POSITION _____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

BUSINESS ADDRESS _____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

CITY _____ STATE _____ ZIP _____

BEST DAYS AND TIME FOR APPOINTMENT: _____

MUSIC PREFERENCE: _____

Closest relative NOT living with you _____ Phone # _____

Person to contact in case of emergency _____ Phone # _____

RELEASE:

I authorized the dentist to perform treatment, medication and therapy that may be needed. I also understand the use of local anesthetic agents embodies certain risks.

PATIENT RESPONSIBILITIES FOR FEES & ASSIGNMENT OF INSURANCE BENEFITS. I understand that responsibility for payment for dental services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid on the day services are provided. I hereby authorize that the payment from the insurance company due me be paid directly to this office. In the event of default in payment patient or party responsible for fees agrees to pay any and all costs of suit, collection and attorney fees.

SIGNATURE _____ Date _____

PATIENT'S NAME _____

Are you under the care of a physician? Physician's name: _____ Yes No

Do you or have you had a pacemaker, artificial heart valve, bypass surgery or heart murmur? Yes No

Year: _____ Medications: _____

Since when _____ Reason _____

Have you had any radiation treatment, or chemotherapy treatment? Year: _____ Yes No

Have you had or do you test positive for hepatitis? Year: _____ Type: _____ Yes No

Do you have dry mouth? _____ Yes No

Blood disorders, such as anemia, leukemia, etc? _____ Yes No

Are you allergic to any medications or substances? Yes No

List: _____

Do you have any other allergies? Yes No

List: _____

Do you have epilepsy or seizure disorders? _____ Yes No

Have you tested positive for HIV? Year: _____ Yes No

Do you have arthritis or rheumatism? _____ Yes No

Do you have any stomach problems? _____ Yes No

Do you have kidney problems? _____ Yes No

Do you have liver problems? _____ Yes No

High or low blood pressure. _____ Yes No

Do you have asthma? _____ Yes No

Are you diabetic? _____ Yes No

Do you have artificial joints/prosthesis? _____ Yes No

Are you sensitive to any metals or latex? _____ Yes No

Have you had psychiatric treatment? _____ Yes No

Are you pregnant or suspect you may be? _____ Yes No

Birth control medication. _____ Yes No

Do you or have you had T.B.? _____ Yes No

Year treated: _____

Do you grind your teeth? _____ Yes No

Do you snore or have sleep disorders? _____ Yes No

Have you had any other disease, surgery, illness, conditions? _____ Yes No

List: _____

Medications you are currently taking: _____
