FREDERICK P. WALDSCHMIDT, D.D.S.

GENERAL DENTISTRY / DENTAL SLEEP MEDICINE

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ❑ M ❑ F Age_____ Birthdate_____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Spouse's Name _____

Birthdate _____

Spouse's SS# _____

Occupation _____

Spouse's Employer _____

Spouse's Employer Address _____

Whom may we thank for referring you?

_____

PHONE NUMBERS

Home _____ Work _____

Ext. _____ Cell _____

Best. phone number to reach you

Email Address _____

IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name _____

Relationship _____ Home _____

DENTAL INSURANCE

Subscriber's Name _____

Birthdate ____ SS# _____

Relation to Patient _____

Insurance Co. _____

Group# _____

Employer _____

Employer Address _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate____ SS# _____

Relation to Patient _____

Insurance Co. _____

Group# _____

Employer _____

Employer Address _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Waldschmidt all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

MEDICATIONS

List all medications, vitamins, herbs, supplements and over-the-counter medications you are currently taking:

_____

_____

_____

Pharmacy name _____ Phone _____

Do you premed before dental procedures? _____ If Yes, Why? _____

Are you taking any blood thinners? (Aspirin, Ibuprofen, Coumadin, Plavix) _____

ALLERGIES

❑ No known allergies
❑ Codeine
❑ Anesthetic
❑ Household Bleach
❑ Aspirin
❑ Ibuprofen
❑ Penicillin
❑ Tetracycline
❑ Jewelry
❑ Latex
❑ Sulfa
❑ Mouth Rinses

DENTAL HISTORY

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Fresher breath? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush?_____

Why have you come to the office?

_____

_____

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Artificial Heart Valves	❑ Yes	❑ No	Cerebral Palsy	❑ Yes	❑ No	Nervous Problems	❑ Yes	❑ No
Congenital Heart Lesions.	❑ Yes	❑ No	Chemical Dependency	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	Chemotherapy	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Heart Problems	❑ Yes	❑ No	Circulatory Problems	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Cortisone Treatments	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Low Blood Pressure	❑ Yes	❑ No	Cough, persistent or bloody	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Mitral Valve Prolapse	❑ Yes	❑ No	Diabetes, is it controlled?	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No	Blood Sugar Level _____			Skin Rash	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No	Do you wear contact lenses?	❑ Yes	❑ No	Swelling of Feet or Ankles	❑ Yes	❑ No
Stroke	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Swollen Neck Glands	❑ Yes	❑ No
Stent	❑ Yes	❑ No	Fainting or dizziness	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Date Placed _____						Tonsilitis	❑ Yes	❑ No
AIDS	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Tumor or growth on head or neck	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Ulcer	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Type _____			Venereal Disease	❑ Yes	❑ No
Asthma or Hay fever	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Weight Loss, unexplained	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No	HIV Positive	❑ Yes	❑ No	WOMEN:		
Bleeding abnormally, with extractions or surgery	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Are you pregnant?	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	Jaw Pain	❑ Yes	❑ No	Due date		
Blood Transfusion	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Is there a possibility of pregnancy?	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No			
			Lung Disease	❑ Yes	❑ No			

Please list any conditions or illnesses not mentioned. _____

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage on the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* **X** _____ Date: **X** _____

This signature on file is my authorization for the release of information necessary to process my claim, I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* **X** _____ Date: **X** _____