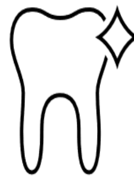
WELCOME TO OUR PRACTICE!



Schall Family Dental, Inc.

Patient Information

Name ____Preferred Name______________
Last Name First Name

Check appropriate Box: Single ☐ Married ☐ Male☐ Female☐

Birthdate _______________________ Soc. Sec # _____________________________

Address__________________________City_________________State_____Zip________

E-Mail____________________________________Mobile Phone ____________________

Patients Employer ___________________________Work Phone ______________________

List anyone in your household currently a patient__________________________________

Who can we thank for referring you? ____

Pesron Responsible for Account __________________DOB ________ Soc Sec # __________

Emergency contact & relationship ________________________/_____________________

Contacts Phone #______________________

Primary Dental Insurance

Please complete OR give us your card to copy

Place of Employment for the Insurance ___________________________

Name Insurance is listed under:_____________________ DOB ________ Soc Sec # _________

Insurance Company ______________________________ Phone # ______________________

Member ID # ___________________________________ Group # ______________________

Additional Dental Insurance

Place of Employment for the Insurance ___________________________

Name Insurance is listed under:_____________________ DOB ________ Soc Sec # _________

Insurance Company ______________________________ Phone # ______________________

Member ID # ___________________________________ Group # ______________________

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you are taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Physician's Name ______________________________ Pharmacy______________________________

Have you ever been hospitalized Or had a major operation?

If yes please explain ____

Have you ever had a serious head or neck injury?

If yes please explain ____

Please list any prescibed medications by name:

____

____

Do you take a Blood Thinner? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No **OR controlled substances?** ○ Yes ○ No

Women **Pregnant and/or trying to get pregnant** ○ Yes ○ No

Are you ALLERGIC to any of the following? Please check:

❑ Aspirin ❑ Amoxicillin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Local Anesthetics

❑ Doxycycline ❑ Myacins ❑ Hydrocodone

If other ALLERGIES please explain: ____

Do you have, or have you had, any of the following?

Condition		Condition		Condition	
ADHD	○ Yes ○ No	Diabetes	○ Yes ○ No	Liver Disease	○ Yes ○ No
AIDS/HIV Positive	○ Yes ○ No	Epilepsy/Seizures	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Mental Disorder	○ Yes ○ No
Allergies	○ Yes ○ No	Fainting/Dizzyness	○ Yes ○ No	Pain in Jaw	○ Yes ○ No
Anemia	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Respiratory Problems	○ Yes ○ No
Arthritis	○ Yes ○ No	GI Problems	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Heart Valve*	○ Yes ○ No	Heart Ailments	○ Yes ○ No	Sleep Apnea	○ Yes ○ No
Artificial Joint*	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	**Shunt***	○ Yes ○ No
Asthma	○ Yes ○ No	Hemophilia	○ Yes ○ No	Stroke	○ Yes ○ No
Autism Spectrum Disorder	○ Yes ○ No	Hepatitis	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Cancer	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cardiac Transplant*	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	MRSA	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	**Infective Endocarditis***	○ Yes ○ No	Other ____________	
Congenital Heart Disorder*	○ Yes ○ No	Kidney Disease	○ Yes ○ No		

*CONDITIONS IN BOLD MAY REQUIRE PREMEDICATION FOR DENTAL WORK

***If you have an artificial joint you are required to find out if you need a Pre-Med from your Physician**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

SIGNATURE OR PATIENT, PARENT OR GAURDIAN ____________________________ **Date** ___________