SCHULMAN
ESTHETIC AND GENERAL DENTISTRY

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Welcome to our office!
Your thoroughness in furnishing the following confidential information will be appreciated.

PLEASE COMPLETE ALL PAGES

TODAY'S DATE:_____ ❒ MALE ❒ FEMALE DATE OF BIRTH: _____

PATIENT'S NAME: _____ NAME YOU ARE CALLED: _____

❒ SINGLE ❒ MARRIED ❒ DIVORCED ❒ WIDOWED SOCIAL SECURITY NO: _____

NAMES & AGES OF YOUR CHILDREN: _____
_____

PARENT'S NAME (IF PATIENT IS A MINOR OR LAST NAME IS DIFFERENT): _____

RESIDENCE ADDRESS: _____
NUMBER & STREET

_____
CITY STATE ZIP

E-MAIL ADDRESS: _____ CELL: _____

RESIDENCE PHONE: _____ BUSINESS PHONE: _____

EMPLOYED BY: _____ OCCUPATION: _____

SPOUSE'S NAME: _____ SPOUSE'S PHONE: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S OCCUPATION: _____

IF COVERED BY DENTAL INSURANCE, PLEASE FILL OUT SECTION BELOW:

NAME OF INSURED: _____ POLICY NO.: _____

DENTAL INSURANCE COMPANY NAME: _____

SECONDARY DENTAL INSURANCE COMPANY: _____ POLICY NO.: _____

MEDICAL INSURANCE NAME: _____

PREVIOUS DENTIST:_____

REASON FOR CHANGE:_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

RELATIONSHIP: _____

IN CASE OF EMERGENCY, YOUR NEAREST RELATIVE (OTHER THAN SPOUSE), NEIGHBOR OR FRIEND **NOT** LIVING WITH YOU TO CONTACT: NAME:_____ RELATIONSHIP:_____

ADDRESS: _____ PHONE: _____

CONTINUED

GENERAL HEALTH HISTORY

Please list any ALLERGY or REACTIONS to medications that you may have:

_____

_____

_____

_____

Please list any DRUGS or MEDICATIONS you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

PHYSICIAN'S NAME: _____ PHONE: _____

DATE OF LAST COMPLETE PHYSICAL: _____

❒ YES ❒ NO HAVE THERE BEEN ANY RECENT CHANGES IN YOUR HEALTH? IF SO, WHAT? _____
_____

❒ YES ❒ NO ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN? IF SO, WHAT CONDITION IS BEING TREATED?
_____

❒ YES ❒ NO HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS OR HOSPITALIZATIONS? IF SO, WHAT? _____
_____

❒ YES ❒ NO ARE YOU EMPLOYED IN A SITUATION WHICH EXPOSES YOU REGULARLY TO X-RAYS OR OTHER IONIZING RADIATION? IF SO, PLEASE EXPLAIN: _____
_____

❒ YES ❒ NO HAVE YOU TAKEN ANY STEROIDS (CORTISONE, PREDNISONE, PREDNISILONE, ETC) IN THE PAST YEAR? IF SO, WHICH ONE(S)? _____
_____

❒ YES ❒ NO DO YOU HAVE ANY ARTIFICIAL JOINTS, HEART VALVES, OR ANY OTHER PROSTHESIS OR IMPLANT?

❒ YES ❒ NO DO YOU REQUIRE PRE-MEDICATION WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT? FOR WHAT MEDICAL CONDITION? _____
WHICH ANTIBIOTIC? _____

❒ YES ❒ NO DO YOU SMOKE? ❒ CIGARETTES ❒ CIGARS ❒ PIPE ❒ SMOKELESS TOBACCO
HOW MANY/MUCH PER DAY? _____

❒ YES ❒ NO DO YOU TAKE VITAMINS OR SUPPLEMENTS? PLEASE LIST: _____
_____

❒ YES ❒ NO ARE YOU TAKING BLOOD THINNERS? PLEASE LIST: _____
_____

WOMEN

❒ YES ❒ NO ARE YOU PREGNANT? IF SO, HOW MANY MONTHS? _____

❒ YES ❒ NO ARE YOU NURSING?

❒ YES ❒ NO ARE YOU TAKING BIRTH CONTROL PILLS?

CONTINUED

GENERAL HEALTH HISTORY (continued)

Please answer ALL questions by circling either YES or NO. If you don't understand a question, go on to the next. The doctor will review it with you. All information is **confidential**.

Do you have or have you had any of the following conditions or diseases?

CARDIOVASCULAR		
Mitral valve prolapse	Y	N
Rheumatic Fever	Y	N
Congenital Heart Defect	Y	N
Angina or Heart Attack	Y	N
Heart Murmurs	Y	N
Congestive Heart Failure	Y	N
Heart Surgery/Pacemaker	Y	N
Stroke	Y	N
Hypertension (high blood pressure)	Y	N
Hypotension (low blood pressure)	Y	N
RESPIRATORY DISEASE		
Asthma or Bronchitis	Y	N
Emphysema	Y	N
Hay Fever or Sinusitis	Y	N
ENDOCRINE DISEASE		
Diabetes	Y	N
Hyperthyroidism (High Thyroid)	Y	N
Hypothyroidism (Low Thyroid)	Y	N
BLOOD DISORDERS		
Anemia	Y	N
Do you bleed excessively when cut?	Y	N
Blood transfusions	Y	N

KIDNEY DISEASE		
Have you had any kidney infections?	Y	N
Have you had kidney surgery?	Y	N
INFECTIOUS DISEASE		
Hepatitis	Y	N
Venereal Disease	Y	N
Tuberculosis	Y	N
HIV Positive	Y	N
MISCELLANEOUS DISEASE and DISORDERS		
Frequent Fainting	Y	N
Liver Disease or Jaundice	Y	N
Arthritis (Rheumatoid or Osteoarthritis)	Y	N
Ulcers	Y	N
Glaucoma	Y	N
Epilepsy	Y	N
Cancer	Y	N
Radiation Therapy for Cancer	Y	N
Chemotherapy	Y	N
Skin Problems/Rashes	Y	N

DENTAL HEALTH HISTORY (NEW PATIENTS ONLY!)

WHEN WAS YOUR LAST DENTAL EXAMINATION? _____

WHEN WAS YOUR LAST DENTAL CLEANING? _____

WHEN WERE YOUR LAST X-RAYS TAKEN? _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____

HOW OFTEN DO YOU FLOSS? _____

WHAT DO YOU CONSIDER YOUR MAJOR DENTAL PROBLEM TO BE? _____

_____

❒ YES ❒ NO DO YOUR GUMS BLEED EASILY WHEN YOU BRUSH OR FLOSS?

❒ YES ❒ NO ARE YOU CONSCIOUS THAT YOU HAVE BAD BREATH?

❒ YES ❒ NO DO YOU HAVE A BAD TASTE IN YOUR MOUTH?

❒ YES ❒ NO HAVE YOUR GUMS EVER BEEN TREATED FOR PERIODONTAL DISEASE?

❒ YES ❒ NO DO YOU HAVE DENTURES/PARTIAL DENTURES/ BRIDGES? WHEN WERE THEY MADE? _____

❒ YES ❒ NO DO YOU HAVE ANY PAIN, POPPING OR CLICKING IN YOUR JAW JOINT (TMJ)? PLEASE DESCRIBE_____

_____

❒ YES ❒ NO HAVE YOU HAD ORTHODONTIC TREATMENT (BRACES)?

❒ YES ❒ NO DO YOU FREQUENTLY GET COLD SORES, BLISTERS OR ANY OTHER ORAL LESIONS?

❒ YES ❒ NO ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH?

❒ YES ❒ NO ARE YOUR TEETH AS WHITE AS YOU WOULD LIKE THEM TO BE?

❒ YES ❒ NO WE FEEL IT IS NECESSARY FOR PROPER DIAGNOSIS AND TREATMENT TO TAKE CAVITY DETECTION X-RAYS, ON MOST PATIENTS, ONE TIME PER YEAR, AND A PANORAMIC X-RAY EVERY THREE YEARS. DO YOU HAVE ANY OBJECTIONS TO THIS?

❒ YES ❒ NO HAVE YOU EVER HAD NITROUS-OXIDE/OXYGEN (GAS) ANALGESIA?

CONTINUED

OFFICE POLICY

We recognize your time is of value and will strive to keep your time spent in our office as short as possible. Please value our time in return by providing us with at least **48 hours advanced notification** if your scheduled appointment cannot be kept. Broken and missed appointments create scheduling problems for other patients and our practice. An advanced notification will allow us to use our time to accommodate other patients. An **hourly charge** with a **$50 minimum** may be applied to your account for broken or missed appointments without adequate advanced notice. Thank you for your cooperation in this matter.

All payments are due at the time the treatment is performed unless other arrangements are made in advance. **We accept Cash, Check, Visa, Mastercard and Discover.** Any payments which become overdue will bear interest at the rate of 2% per month or a minimum charge of $2.00, whichever is greater, from the date the payment was due until it is paid in full. The patient will pay all cost of collections, including reasonable amount of attorney's fees.

For patients with dental insurance, as a courtesy, we will accept assignment of your insurance benefits. A copy of your insurance card and verification of benefits must be complete prior to billing your insurance company. We will gladly **estimate** your insurance benefits and will expect your portion of the fee to be paid at each visit. After insurance pays on your claim, you are responsible for any portion your insurance company does not cover. If your insurance company pays less than what was estimated, you will be responsible for the balance.

If the patient is a minor; I the parent or legal guardian being the undersigned below, authorize Dr. Schulman or associate(s) to treat the named patient, under the laws of the state of Georgia, in my absence, and to perform those dental procedures they deem necessary.

The general health history and other information that I have provided is accurate to the best of my knowledge. I agree to pay the percentage of the fee that Dr. Schulman's office estimates will not be covered by insurance at the time of the treatment.

_____
Patient's Signature

_____ _____
Doctor's Signature Parent or Guardian's Signature

_____ _____
Today's Date Today's Date

If, at any time, you have any questions regarding your treatment, appointments, or fees, please feel free to ask. Thank you for allowing us to serve you.

END