

WALDEN SQUARE DENTAL CARE

Welcome!!

We are pleased to welcome you and your family to our practice! Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health!

Name _____ Today's date _____

Address _____

City _____ State _____ Zip _____

E-Mail _____ Sex M F Birthdate _____ S. S. # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Name of Spouse/Partner _____

Name of Responsible Party _____ Name of Employer _____

IN Case of an Emergency, Contact : Name _____ phone _____

How did you hear about our practice? _____

HEALTH HISTORY

Physician's Name _____ Phone _____ Date of last visit _____

Recent hospitalizations or surgeries: _____

Medications: _____

Do you have or have you had any of the following:

Heart problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Seizure disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart attack	<input type="checkbox"/> yes <input type="checkbox"/> no	Glaucoma	<input type="checkbox"/> yes <input type="checkbox"/> no	Tonsillitis	<input type="checkbox"/> yes <input type="checkbox"/> no
High Blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	HIV	<input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no	Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	Ulcer	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart murmur	<input type="checkbox"/> yes <input type="checkbox"/> no	Abnormal bleeding	<input type="checkbox"/> yes <input type="checkbox"/> no	Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no
Mitral valve prolapse	<input type="checkbox"/> yes <input type="checkbox"/> no	Blood disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Chemotherapy	<input type="checkbox"/> yes <input type="checkbox"/> no
Pacemaker	<input type="checkbox"/> yes <input type="checkbox"/> no	Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	Radiation treatment	<input type="checkbox"/> yes <input type="checkbox"/> no
Rheumatic fever	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Tumors or growths	<input type="checkbox"/> yes <input type="checkbox"/> no
Scarlet fever	<input type="checkbox"/> yes <input type="checkbox"/> no	Liver disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Cortisone treatments	<input type="checkbox"/> yes <input type="checkbox"/> no
Allergies	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no
Sinus trouble	<input type="checkbox"/> yes <input type="checkbox"/> no	Herpes	<input type="checkbox"/> yes <input type="checkbox"/> no	Nervous problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	Jaundice	<input type="checkbox"/> yes <input type="checkbox"/> no	Psychiatric care	<input type="checkbox"/> yes <input type="checkbox"/> no
Emphysema	<input type="checkbox"/> yes <input type="checkbox"/> no	Respiratory disease	<input type="checkbox"/> yes <input type="checkbox"/> no		
Headaches	<input type="checkbox"/> yes <input type="checkbox"/> no	Shortness of breath	<input type="checkbox"/> yes <input type="checkbox"/> no		

Do you smoke? yes no

Have you taken any immunosuppressant medication (Humera) ? yes no

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? (Ionimin, Adipex, Fastin, Pondimin, Redux) yes no

Have you ever taken an antiresorptive osteoporosis medication? These include Fosamax, Alendro, Actonel, Boniva, Aredia, Pamisol, Zometa, and Reclast yes no

Are you allergic to any medications? yes no

If yes, please list the medications:

WOMEN:

Are you pregnant? yes no ... Nursing? yes no ...taking birth control pills? yes no

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health.

Name

Date

DENTAL HISTORY

Reason for today's visit _____

Do you have any problem not listed above that you think we should know about?

Have you had any serious trouble associated with any previous dental treatment?

Please indicate if you have had any of the following:

Bleeding gums yes no

Blisters/canker sores yes no

Clicking or popping jaw yes no

Grinding teeth yes no

Sensitivity to cold or heat yes no

Dry mouth yes no

Periodontal treatment yes no

Orthodontic treatment yes no

DENTAL INSURANCE

Insurance company _____

Secondary insurance:

Group # _____ Phone# _____

Insurance company _____

Subscriber _____

Group # _____ Phone# _____

Birthdate _____ SS# _____

Subscriber _____

Birthdate _____ SS# _____

I hereby assign directly to Dr. Elizabeth M. Schaik, D.D.S. all insurance benefits for services rendered. The dentist may use my and/or my minor child's health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions, whether manual or electronic.

I understand that the most appropriate dental treatment will be recommended by the dentist. The dentist cannot and will not base treatment recommendations upon insurance benefits. Sometimes the most proper treatment is not a covered expense.

I understand that insurance claims will be filed directly from the office, and the dentist will wait 60 days for a response or compensation. After 60 days, the unpaid charges will be billed directly to me and any insurance communications become my responsibility.

In the event that unpaid charges are turned over to a collection agency, information will be given to the agency and may include, but is not limited to: name, address, phone number, social security number, employment and employment phone number. I will be responsible for the account balance as well as any collection fees.

I understand that when I make an appointment, the office reserves that time for ME and last-minute cancellations are difficult to remedy. A fee (usually \$50 for a 45-min. appt.) will be charged for any cancellation less than 24 hours before the appointment.

Name _____ Date _____