PATIENT NAME _____ DATE _____

Primary reason for initial dental appointment: ☐ Routine Examination/Cleaning ☐ Emergency ☐ Consultation

DENTAL & MEDICAL HISTORY

Do you have dental examinations on a routine basis?	☐ Yes	☐ No	Last visit _____
Do you think you have active decay or gum disease?	☐ Yes	☐ No	Discuss _____
Do you brush and floss on a routine basis?	☐ Yes	☐ No	
Do your gums ever bleed?	☐ Yes	☐ No	Discuss _____
Do you ever have clicking, popping or discomfort in the jaw joint?	☐ Yes	☐ No	Discuss _____
Do you grind your teeth?	☐ Yes	☐ No	Discuss _____
Have your past dental experiences been positive?	☐ Yes	☐ No	Discuss _____
Have you ever smoked or chewed tobacco?	☐ Yes	☐ No	Discuss _____
Do you have any sores or growths in your mouth?	☐ Yes	☐ No	Discuss _____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	Discuss _____
Are you on a special diet?	☐ Yes	☐ No	Discuss _____
Are you under a physician's care now?	☐ Yes	☐ No	Why? _____
			Name of Physician _____

Name of previous dentist (optional) _____

Date of last full mouth xrays (16 individual films or panoramic) _____

Are you taking any prescription medications or a regular regimen of aspirin? _____

Are you allergic to any medications or substances? Please check box below

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Milk ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing Discuss _____

Do you now or have you ever had any of the following? Please check appropriate box for EVERY item listed below.
*If yes to any of the starred conditions, please call prior to your appointment as premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	☐	☐	Irregular Heart Beat	☐	☐	Hemophilia	☐	☐	Cancer	☐	☐
Heart Murmur or Defect*	☐	☐	Angina/Chest Pain	☐	☐	Leukemia	☐	☐	X-Ray Treatment (Radiation)	☐	☐
Congenital Heart Disorder*	☐	☐	Heart Attack/Failure	☐	☐	Recent Blood Transfusion	☐	☐	Chemotherapy	☐	☐
Mitral Valve Prolapse*	☐	☐	Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Osteoporosis	☐	☐
Artificial Heart Valve*	☐	☐	Rheumatic Fever	☐	☐	Lung Disease	☐	☐	Bisphosphonates	☐	☐
Heart Pace Maker*	☐	☐	High Blood Pressure	☐	☐	Breathing Problem	☐	☐	Osteonecrosis of the Jaw	☐	☐
Pulmonary Shunt*	☐	☐	Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Aredia I.V. Reclast I.V.	☐	☐
Bacterial Endocarditis*	☐	☐	Bruise Easily/Blood Disease	☐	☐	Asthma	☐	☐	Zometa I.V.	☐	☐
Coronary Stent*	☐	☐	Anemia	☐	☐	Emphysema	☐	☐	Fosamax, Actonel or Boniva	☐	☐
Artificial Joint*	☐	☐	Sickle Cell Disease	☐	☐	Tuberculosis	☐	☐	Stomach/Intestinal Disease	☐	☐
Diabetes	☐	☐	Hypoglycemia	☐	☐	Liver Disease	☐	☐	Hepatitis A (Infectious)	☐	☐
Kidney Problems	☐	☐	Renal Dialysis	☐	☐	Cortisone Medicine	☐	☐	Hepatitis B or C	☐	☐
Thyroid Disease	☐	☐	Arthritis/Gout	☐	☐	Drug Addiction/Alcoholism	☐	☐	Sexually Transmitted Disease	☐	☐
Parathyroid Disease	☐	☐	Rheumatism	☐	☐	Cold Sores	☐	☐	AIDS	☐	☐
Stroke	☐	☐	Convulsions	☐	☐	Fever Blisters	☐	☐	HIV Positive	☐	☐
Glaucoma	☐	☐	Epilepsy or Seizures	☐	☐	Herpes	☐	☐	Genital Herpes	☐	☐
Sleep Apnea	☐	☐	Fainting or Dizziness	☐	☐	Tumors or Growths	☐	☐	Nervousness	☐	☐
Alzheimer's Disease	☐	☐	Cochlear Implants	☐	☐	Need Premedication*	☐	☐	Psychiatric Care	☐	☐

Have you ever had any other serious illness not listed above? Specify _____

X _____ Date _____

Patient Signature (Parent or Guardian)

Reviewed By Doctor or Hygienist _____ Date _____

UPDATES TO MEDICAL HISTORY

I have reviewed my above filled in medical history and confirm that it is up to date with my past and present medical conditions. Any exceptions are listed below.

Date	Exceptions		Patient Signature	Reviewing Dr.
		None ☐		
		None ☐		
		None ☐		
		None ☐		

PLEASE PRINT CLEARLY

NAME _____ GOES BY _____
LAST FIRST MI NICKNAME

SOCIAL SECURITY # _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE

ADDRESS _____
STREET APT # CITY STATE ZIP

BIRTHDATE _____ PHONE _____
MO / DAY / YEAR HOME WORK CELL

EMAIL _____

NAME OF EMPLOYER _____

IF FULL TIME STUDENT, NAME OF SCHOOL _____

Which types of appointment reminders would you like to receive? **Choose all that apply** ☐ Email ☐ Text ☐ Call

Which reminder frequencies would you like to receive? **Choose all that apply**
☐ Immediate Calendar Reminder ☐ 4 weeks prior to appt ☐ 1 day prior to appt ☐ 2 hours prior to appt

PERSON RESPONSIBLE FOR ACCOUNT – **PLEASE CHECK ONE: ☐ PATIENT ☐ SPOUSE ☐ MOTHER ☐ FATHER

INSURANCE INFORMATION – PLEASE FILL IN ACCORDINGLY

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
LAST FIRST	LAST FIRST
SSN BIRTHDATE RELATIONSHIP TO PATIENT	SSN BIRTHDATE RELATIONSHIP TO PATIENT
DENTAL INSURANCE COMPANY INSURANCE PHN #	DENTAL INSURANCE COMPANY INSURANCE PHN #
SUBSCRIBER/EMPLOYEE ID # GROUP #	SUBSCRIBER/EMPLOYEE ID # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____

Are you interested in participating in our Patient Portal where you can communicate securely with our office? ☐ Y ☐ N

How did you hear of our office? _____

AUTHORIZATION

I hereby authorize my insurance carrier to submit payment directly to Schmidtke Dental for services provided to me in this office. I grant permission to Schmidtke Dental to submit my dental/medical history and other information about my dental treatment to third party payers and/or other health professionals by any method, including electronic transfer.

X _____ _____
Patient or Responsible Party Date

CONFIDENTIAL PATIENT INFORMATION

Thank you for choosing Schmidtke Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of care as simple and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- In-House Financing up to 90 days with 15% added interest (Credit/Debit Card Required)
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Schmidtke Dental requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $45 is charged for patients who miss or cancel an appointment without a 24 business hour notice.

Schmidtke Dental charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality of care that you desire and deserve.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier for any reason, you will be responsible for any balance remaining.

SCHMIDTKE DENTAL, P.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 15, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the form of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatments: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorizations: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in this Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as duplicated x-rays. You may also request access by sending us a letter to the address at the end of this Notice. If you request x-rays, we will charge you $20.00 for the duplication film and processing costs. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complain to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Amber Swinney **Phone: (520) 885-9977** **Fax: (520) 546-1880** **Email: schmidtketucson@yahoo.com**

Schmidtke Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given to opportunity to review a copy of Schmidtke Dental's Notice of Privacy Practices.

_____

(Print Name)

_____

(Signature)

_____

(Date)

For Official Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify):

_____

_____

_____