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

Group #_____ Phone#_____

Subscriber_____

Birthdate_____ SS#_____

Secondary insurance:

Insurance company_____

Group #_____ Phone#_____

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_____