**New Patient Information**

**Welcome to our practice**

Please take your time to fill out this form completely. The more we learn about you the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Today’s date

First name Middle initial Last name

I prefer to be called (nickname, etc.) Male Female

Address City State ZIP

Date of birth Social Security No.

Home phone ( ) - Work phone ( ) - Cell phone ( ) -

Primary contact number (please check one)  Home Work

E-mail Driver’s license no.

Employer Occupation

Spouse’s name Spouse’s employer

Whom may we thank for referring you?

**Primary Carrier:**

Insurance co. name: Insurance co. phone

Group no. (plan or policy ID)

Insured name: Relationship of patient:

Date of birth:­­ Insured Social Security no.:

Insured’s employer name:

**Preferred payment method (circle): Cash Credit card Check**

Visa/MC/Amex no:

**Dental History**

Reason for today’s visit

Are you currently in pain? Yes No

If so, please describe:

Do you have any dental problems now? Yes No

If so, please describe:

Have you ever had trouble with a previous dental treatment? Yes No

If so, please describe:

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Previous dentist’s name

City State Phone ( ) -

Why are you changing dentists?

How often do you have dental examinations? How often do you brush your teeth?

How often do you floss?

What other dental aids do you use? (Electric toothbrush, toothpick, etc.)

Do you require antibiotics before dental treatment?

 Yes No

Do you have frequent headaches? Yes No

Do your gums ever bleed? Yes No

Do you clench or grind your teeth? Yes No

Have you noticed any mouth odors or bad tastes?

Yes No

Are your teeth sensitive to heat/cold?

Yes No

Do you bite your lips or cheeks frequently?

Yes No

Do you still have your wisdom teeth? Yes No

**Have you ever had:**

Periodontal disease/gum treatment Yes No

Discomfort in your jaw joint (TMJ/TMD) Yes No

Orthodontics treatment Yes No

Your teeth ground or bite adjusted Yes No

Oral surgery Yes No

Serious injury to the mouth or head Yes No

If yes to any of the previous questions, please describe

Is there anything else about your past dental treatment(s) that you would like us to know?

Have you been hospitalized or under the care of a medical doctor during the past 2 years? Yes No

If yes, for what?

Are you currently taking any medications or drugs? Yes No

If yes, please explain

Have you been to the doctor to check for heart problems? Yes No

If so, what are the problems?

**Women only:**

Are you pregnant or think you may be pregnant? Yes No Are you nursing? Yes No

Are you taking birth control pills? Yes No

**Medical History**

**Indicate which of the following you have had or have at present (circle all that apply):**

Yes No AIDS/HIV

Yes No Alcohol/Drug Abuse

Yes No Allergies or Hives

Yes No Anemia

Yes No Arthritis/Rheumatism

Yes No Artificial Heart Valve

Yes No Artificial Bones/Joints

Yes No Asthma

Yes No Blood Disease

Yes No Blood Transfusion

Yes No Bruise Easily

Yes No Cancer/Chemotherapy

Yes No Chest Pain

Yes No Cold Sores/Herpes

Yes No Colitis

Yes No Cortisone Medicine

Yes No Diabetes

Yes No Diet (Special/Restricted)

Yes No Difficulty Breathing

Yes No Emphysema

Yes No Epilepsy or Seizures

Yes No Fainting or Dizzy Spells

Yes No Frequent Headaches

Yes No Glaucoma

Yes No Heart (Surgery, Disease, Attack)

Yes No Heart Pacemaker

Yes No Heart Murmur

Yes No Hemophilia/Abnormal Bleeding

Yes No Hepatitis A B C (circle)

Yes No High or Low Blood Pressure

Yes No Hospitalized for Any Reason

Yes No Jaundice

Yes No Kidney Trouble

Yes No Liver Disease

Yes No Lupus

Yes No Mitral Valve Prolapse

Yes No Nervousness/Anxiety

Yes No Neurological Disorders

Yes No Psychiatric/ Psychological Care

Yes No Radiation Therapy

Yes No Rheumatic/Scarlet Fever

Yes No Shingles/Chicken Pox

Yes No Sickle Cell Disease/Traits

Yes No Sinus Trouble

Yes No Snoring/Sleep Apnea

Yes No Stomach Problems/ Ulcers

Yes No Stroke

Yes No Swollen Ankles

Yes No Thyroid Problems

Yes No Tuberculosis (TB)

Yes No Tumors

Yes No Venereal Disease/STD

Please list any serious medical condition(s) that you have ever had not listed above:

Please list any medication/products that you might be allergic to:

Are you taking any herbal supplements or vitamins? If so please list:

Signature of patient (or parent/guardian) Date:

Print:

**Financial Policy**

Thank you for choosing us for your dental care. We want to assure you that all treatment recommended for you will be based on your individual needs and will not be influenced by any insurance companies coverage. We pride ourselves on providing optimum dental care; any treatment we recommend for you would also be treatment we would recommend for a member of our own family.

We ask that you read and sign the following financial policy before seeing our doctor.

Payment is due in full at the time of treatment (unless prior arrangements have been approved). We accept multiple forms of payment for your convenience and we also offer extended payment plans with prior credit approval.

If you need extensive dentistry that will require a number of visits to complete, our financial coordinator will discuss financial arrangements with you prior to initiation of treatment.

I understand Eva Schwartz DDS shall provide the complimentary filing of my dental claims with the information provided on these forms. Should further information become necessary, I authorize Eva Schwartz DDS. to ask the representatives, healthcare provider or agencies provided to release such information to the office.

I understand it is my responsibility to notify the office of any changes to my medications, health, and

insurance policies.

I understand I am responsible to pay for services rendered, including reasonable attorney fees and costs of collection in the event of default. I authorize Eva Schwartz DDS. to charge any unpaid balance to my preferred method of payment on file after my insurance has (or has not) paid. There will be a finance charge of $75.00 for all balances past 60 days.

I understand that my appointments are reserved according to my convenience and there may be a $100 charge for any missed appointments or cancellations within 48 hours of the appointment.

I understand that all minors must be accompanied by a parent or guardian and that parent or guardian is responsible for payment at time of service.

Signature of patient (or parent/guardian) Date:

Print:

**PATIENT HIPAA CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health

information. These rights are given to me under the Health Insurance Portability and

Accountability Act of 1996 (HIPAA). I understand that by signing this consent I

authorize you to use and disclose my protected health information to carry out:

• Treatment (including direct or indirect treatment by other healthcare providers

involved in my treatment);

• Obtaining payment from third party payers (e.g. my insurance company);

• The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your

Notice of Privacy Practices, which contains a more complete description of the uses and

disclosures of my protected health information and my rights under HIPAA. I understand

that you reserve the right to change the terms of this notice from time to time and that I

may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health

information is used and disclosed to carry out treatment, payment and health care

operations, but that you are not required to agree to these requested restrictions.

However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or

disclosure that occurred prior to the date I revoke this consent is not affected.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eva T. Schwartz, D.D.S

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