

Haley E. Schmitt, D.D.S  
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## WELCOME

Patient Information (Confidential)

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ May we confirm your appointment via email? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Check appropriate status: Minor \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated \_\_\_

Patient's or Patient/Guardian Employed: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse or Parent's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If patient is a student, name of School/College: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Responsible Party

Person responsible for this account: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Is this person currently a patient in our office? \_\_\_\_\_

### Insurance Information (Please provide insurance card)

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Name of Physician/and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health?  Excellent  Good  Fair  Poor

**DO YOU HAVE or HAVE YOU EVER HAD:**

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____	<input type="checkbox"/>	<input type="checkbox"/>	28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			29. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa			33. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			34. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			37. STI / STD / HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			38. hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	42. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	43. emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	45. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol / recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>ARE YOU:</b>		
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	53. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	54. considered a touchy / sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	56. taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	57. currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c = _____)	<input type="checkbox"/>	<input type="checkbox"/>	58. prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.  
(i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# DENTAL HISTORY

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
 Referred by \_\_\_\_\_ How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor  
 Previous Dentist \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_ Months/Years   
 Date of most recent dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent x-rays \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of most recent treatment (other than a cleaning) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 I routinely see my dentist every:  3 mo.  4 mo.  6 mo.  12 mo.  Not routinely

**WHAT IS YOUR IMMEDIATE CONCERN?** \_\_\_\_\_

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:**

**YES NO**

**PERSONAL HISTORY**

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [\_\_\_\_] \_\_\_\_\_
2. Have you had an unfavorable dental experience? \_\_\_\_\_
3. Have you ever had complications from past dental treatment? \_\_\_\_\_
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_
6. Have you had any teeth removed or missing teeth that never developed? \_\_\_\_\_

**GUM AND BONE**

7. Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_
9. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_
10. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
11. Have you ever experienced gum recession? \_\_\_\_\_
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? \_\_\_\_\_

**TOOTH STRUCTURE**

14. Have you had any cavities within the past 3 years? \_\_\_\_\_
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? \_\_\_\_\_
18. Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_
20. Do you frequently get food caught between any teeth? \_\_\_\_\_

**BITE AND JAW JOINT**

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? \_\_\_\_\_
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_
25. Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_
26. Are your teeth developing spaces or becoming more loose? \_\_\_\_\_
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? \_\_\_\_\_
28. Do you place your tongue between your teeth or close your teeth against your tongue? \_\_\_\_\_
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_
30. Do you clench your teeth in the daytime or make them sore? \_\_\_\_\_
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? \_\_\_\_\_
32. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

**SMILE CHARACTERISTICS**

33. Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_
34. Have you ever whitened (bleached) your teeth? \_\_\_\_\_
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? \_\_\_\_\_
36. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Financial Agreement

1. At your appointment, your services will be filed with your insurance as a courtesy and your *ESTIMATED* portion is collected. **Payment is due in full** the day of the appointment as services are rendered. Each dental insurance policy is different, and it is your responsibility to know and understand your individual benefits. Please note, we are unable to know exactly how much your insurance company will cover until we receive payment on the submitted services. If your insurance company does not cover a portion of the treatment performed, you will be responsible for the balance. For your convenience, we accept all major credit cards. There will be a \$24 returned check fee assessed to your account if a payment is returned to us for any reason.
  
2. **Dental Insurance: Haley E. Schmitt DDS** strives to provide our patients with the best quality of care available and base our treatment recommendations on what we feel is best for your oral health not what your insurance company does or does not pay for. Please review the following regarding dental insurance coverage:
  - a. As a dental care provider, our relationship is with you the patient and not your dental insurance company. Your dental insurance is a contract between you and your insurance company.
  - b. As a courtesy, we will file your insurance claim for you at the time services are rendered. Please note, any amount that is not paid by your insurance company is the patient's responsibility. This may include deductibles, co-payments, frequencies, and procedures not covered by your dental insurance.
  - c. Some insurance companies downgrade services. They determine if they will pay for a less costly service than the covered service performed by the dentist. For example, composite fillings and porcelain crowns may be downgraded to amalgam fillings and full metal crowns. The difference between the services performed and the less costly service is the patient's responsibility. Any co-payment that is collected at the time of visit is an ESTIMATE. Please understand that it is ultimately your responsibility to find out if your insurance is in or out of network with us.
  - d. If you do not provide your dental insurance before your appointment, or if you do not know what your dental insurance is, please contact who provides you with the plan.
  - e. When dental claims are returned due to incorrect information being given, please acknowledge that after 30 days, insurance may no longer cover services. At this time, we will no longer submit the claim for the services provided, we will ask that services be paid for in full. Thank you for understanding.
  
3. **Confirmation/Cancellation Policy:** In order to accommodate our patient's needs, we require all appointments to be confirmed 48 hours prior to the scheduled date. If your appointment is not confirmed this can delay your treatment. We require a minimum of 48 hour notice prior if unable to keep your appointment. If notice is not given there will be a \$50 charge per hour, notated on your account.

**By signing below, I have read and understand my financial obligation and agree to abide by this policy.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Photo and Testimonial Release

I, \_\_\_\_\_ hereby grant permission to Haley E. Schmitt DDS Cosmetic & Family Dentistry to use my photograph and any testimonial or review I give regarding the dental care I have received in any print and electronic form including, but not limited to, marketing, contests, advertising and educational materials used to advertise the dental practice. This may include use on the Schmitt Dental website and social media pages. I acknowledge the right of Schmitt Dental to crop or otherwise edit any photograph, testimonial or review at their discretion. I also acknowledge that Schmitt Dental may choose not to use my photograph, testimonial or review at this time but may do so at their discretion at a later date.

I understand the policy that Haley E. Schmitt DDS is only to use first name and last initial when labeling photographs, reviews and testimonials.

\_\_\_\_\_  
**Patient/ Legal Guardian Name (Print)**

\_\_\_\_\_  
**Patient/Legal Guardian Signature**

\_\_\_\_\_  
**Date**

## Patient Rights

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**Access:** You have the right to look at our obtain copies of your health information, with limited exceptions. Access to health information must be requested in writing. 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 copies and staff time. You may also obtain access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you \$18.00 to copy your dental information and x rays, and postage if you would like the copies mailed to you. 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 March, 29, 2019. 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, but if we do, we will abide by our agreement (except for in an emergency).

**Alternative Communication:** You have the right to request that we communicate with your about your health information by alternative means of 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 show be amended). We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

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### Questions and Complaints

If you would lie 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 voice your complaint to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to privacy of your health information. We will not retaliate in any way you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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