# SCHEIER Family DENTISTRY PATIENT INFORMATION

Email_____

Cell#_____home#_____work#_____

PATIENT NAME: _____

PATIENTADDRESS:_____CITY_____ZIP_____

SOCIAL SECURITY#_____BIRTHDAY_____

**ALLERGIES: PLEASE CIRCLE:** PENICILLIN SULFA CODEINE ASPIRIN HAYFEVER
OTHER SPECIFY _____
LATEX ALLERGY_____
DO YOU TAKE BLOOD THINNERS: _____
ARE YOU TAKING OVER THE COUNTER MEDICATIONS _____
Have you **EVER** TAKEN OR ARE YOU CURRENTLY TAKING ANY MEDICATION FOR OSTEOPENIA/OSTEOPOROSIS CIRCLE: YES NO LIST MEDICATION_____

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE A PRESENT

- Chest Pain
- Congenital Heart Disease
- Heart Murmur
- Artificial Heart Valve
- Heart pacemaker
- Rheumatic Fever
- Arthritis / rheumatism
- Cortisone Medicine
- Stroke
- Kidney trouble
- Ulcers
- Diabetes
- Thyroid Problems
- Glaucoma
- Tuberculosis
- Asthma
- Chronic cough
- Liver Disease
- Sinus Trouble / Surgery
- Nervous/ anxiety
- Psychiatric / Psychological Medication _____

- High Blood Pressure
- Veneral Disease
- A.I.D.S.
- H.I.V. Positive
- Cold sores / Fever Blisters
- Blood Transfusion
- Hemophillia
- Bruises Easily

- Artificial Joints
  - -PreMed_____
- Cancer – Type _____
  - Radiation therapy_____
  - Chemo Therapy_____
- Tumor
- Hepatitis A B C other _____
- Epilepsy or Seizures
- Fainting or dizzy Spells
- Migraines Headaches
- Tobacco Usage_____
- Drug Abuse_____

CURRENT MEDICATIONS-
_____

I understand the above information is necessary to provide me with treatment in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any changes in my health or medication.

Signature_____
DATE:_ _____

REFERRED BY _____

# SCHEIER Family DENTISTRY PATIENT INFORMATION

ACKNOWLEDGEMENT OF RECEIPT PF NOTICE OF PRIVACY PRACTICES

** You May refuse to Sign this Acknowledgement**

I have reviewed or received a copy of this office's Notice of Privacy Practices.

Print Name: _____Date: _____

SIGNATURE: _____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

DENTAL INSURANCE INFORMATION

PRIMARY

EMPLOYER_____

Subscriber: _____

Subscriber Birthdate: _____

ID/SSN _____ _

Group Number _____

Company: _____

Address_____

_____

SECONDARY

EMPLOYER_____

SUBSCRIBER: _____

Subscriber Birthdate: _____

ID/SSN _____

Group Number _____

Company: _____

_____

_____

I give my permission to share my dental records with specialists and the following people

I give permission for Scheier Family Dentistry Staff and doctors to leave information on my home phone and or cell phone in reference to treatment,

SCHEIER Family DENTISTRY PATIENT INFORMATION

Pre- Authorizations and account.

I give permission for Scheier Family Dentistry to discuss treatment, pre-authorization and account with my:

Spouse, Mother, Father, Legal Guardian

Signature_____Date_____