Patient Registration

First Name: _____ Last Name: _____ Initial _____

Preferred Name: _____

Patient is: ◯ Policy Holder ◯ Responsible Party Referred By: _____

Address: _____

City, State Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Date of Birth: _____ Social Security #: _____

Email: _____

◯ I would like to receive correspondence by email ◯ I would like to receive correspondence by text

Marital Status: ◯ Single ◯ Married ◯ Widowed

Emergency Contact:

Name: _____ Phone: _____

Preferred Pharmacy:

Name: _____ Phone: _____

Student Status:

◯ Full Time ◯ Part Time School: _____

Primary Dental Insurance: Circle Relationship to Insured: Self Spouse Child Other

Name of Insured: _____ Insured's Date of Birth: _____

Employer: _____ Insured's ID/SS#: _____

Insurance Company: _____ Phone: _____

Address: _____

Secondary Dental Insurance: Circle Relationship to Insured: Self Spouse Child Other

Name of Insured: _____ Insured's Date of Birth: _____

Employer: _____ Insured's ID/SS#: _____

Insurance Company: _____ Phone: _____

Address: _____

Dr. James l. Schumacher, DMD

UPDATED MED HISTORY

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions carefully and thoroughly.

If yes list

Are you under a physician's care now?	○ Yes ○ No	If yes	
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
Are you taking any medications, pills, or drugs? if yes, list	○ Yes ○ No	If yes	
Medications (including vitamins & supplements) Continued:			
Are You taking blood thinners?	○ Yes ○ No	If yes	
Prescribing Doctor's Name and Phone Number:			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Do you use tobacco?	○ Yes ○ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other Allergy?	○ Yes ○ No	If yes	
Do you take antibiotics prior to dental treatment?	○ Yes ○ No	If yes	

Comments:

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UPDATED MED HISTORY

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Hemophilia	Yes	No
Alzheimer's Disease	Yes	No	Hepatitis A	Yes	No
Anaphylaxis	Yes	No	Hepatitis B or C	Yes	No
Anemia	Yes	No	Herpes	Yes	No
Angina	Yes	No	High Blood Pressure	Yes	No
Arthritis/Gout	Yes	No	High Cholesterol	Yes	No
Excessive Bleeding	Yes	No	Shingles	Yes	No
Hypoglycemia	Yes	No	Asthma	Yes	No
Irregular Heartbeat	Yes	No	Blood Disease	Yes	No
Kidney Problems	Yes	No	Leukemia	Yes	No
Breathing Problems	Yes	No	Liver Disease	Yes	No
Bruise Easily	Yes	No	Swelling of Limbs	Yes	No
Glaucoma	Yes	No	Thyroid Disease	Yes	No
Hay Fever	Yes	No	Tonsillitis	Yes	No
Heart Attack/Failure	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No	Tumors or Growths	Yes	No
Heart Pacemaker	Yes	No	Ulcers	Yes	No
Heart Trouble/Disease	Yes	No	Venereal Disease	Yes	No
Aspirin Therapy	Yes	No	Artificial Joints	Yes	No
Cortisone Medicine	Yes	No	Radiation Treatments	Yes	No
Diabetes	Yes	No	Recent Weight Loss	Yes	No
Drug Addiction	Yes	No	Renal Dialysis	Yes	No
Easily Winded	Yes	No	Rheumatic Fever	Yes	No
Emphysema	Yes	No	Rheumatism	Yes	No
Epilepsy or Seizures	Yes	No	Artificial Heart Valve	Yes	No
Hives or Rash	Yes	No	Excessive Thirst	Yes	No
Sickle Cell Disease	Yes	No	Fainting Spells/Dizziness	Yes	No
Sinus Trouble	Yes	No	Frequent Cough	Yes	No
Blood Transfusion	Yes	No	Stomach/Intestinal Disease	Yes	No
Frequent Headaches	Yes	No	Stroke	Yes	No
Low Blood Pressure	Yes	No	Cancer	Yes	No
Lung Disease	Yes	No	Chemotherapy	Yes	No
Mitral Valve Prolapse	Yes	No	Chest Pains	Yes	No
Osteoporosis	Yes	No	Cold Sores/Fever Blisters	Yes	No
Pain in Jaw Joints	Yes	No	Congenital Heart Disorder	Yes	No
Parathyroid Disease	Yes	No	Convulsions	Yes	No
Psychiatric Care	Yes	No	AFIB	Yes	No
Sleep APNEA	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

PLEASE CIRCLE YES OR NO PATIENT NAME: _____

*** Date of last dental visit & for what _____

1. Are you presently in pain? YES NO
   Teeth Jaw Gums Face Other

2. Have you lost any teeth? YES NO
   If the teeth were replaced, how?_____

3. Is any part of your mouth sensitive to the following? YES NO
   Hot Cold Pressure Sweet Sour Other

4. Do you have a burning sensation in your mouth? YES NO
   Have you experienced unusual dryness of the mouth? YES NO

5. Have you ever had periodontal treatment or gum surgery? YES NO
   If YES,when?_____ By whom?_____

6. Do your gums bleed when you brush your teeth? YES NO

7. Does food catch between your teeth? Where?_____ YES NO

8. Are you aware of a bad taste or odor in your mouth? YES NO

9. Are you aware of any growths or swellings in your mouth? YES NO
   If YES, where are they located and how long have they existed?
   _____

10. Are you aware of your jaw clicking, popping or making grating-like noises;
    or do your muscles feel tired, stiff or painful? YES NO

11. Do you clench or grind your teeth during the day or night YES NO

12. Are you aware of pain in your neck and/or head YES NO
    If yes, where _____

13. Do you have headaches? YES NO
    How often & where_____

14. What do you like BEST about your teeth? What do you like LEAST?
    _____ _____

15. Do you have any anxieties about dental treatment? YES NO
    Please explain,_____

16. Do you have any questions or concerns? YES NO
    If YES, please explain _____

DENTAL HISTORY

Our Financial Alliance

Our Philosophy
Our goal in discussing financial arrangements with you is straightforward:

To create an understanding and partnership in the settlement of your account.

It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account, from the start through final payments to be perceived as an extension of the dental care we provide you and your family.

Patient's Role
As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment in a timely manner. Our staff will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

In developing a financial arrangement it is important to remember your dental future. Our experience has shown that when an account lingers, patients are likely to defer their appointments. It is discouraging to add new charges to an account when tiring to pay off old charges. With this in mind, we will concentrate our efforts on clearing your account in as short a time as is comfortable for both of us.

All patients must complete our Patient Registration and Medical History before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS OR MASTERCARD, VISA, DISCOVER & AMERICAN EXPRESS
WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL

Regarding Insurance
We may accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 30 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

____As part of the financial arrangement process, we will **estimate** what your insurance company will pay. We very much appreciate payment of your uninsured portion upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within **14 days.**

Additionally
____I understand that Dr. Schumacher is NOT a Medicare or a Medicaid provider and *will not be billing* Medicare or Medicaid for any of my services.

____I understand there is a $1.45 "re-billing fee" for statements sent if not paid in full upon receipt.

I have read the Financial Alliance. I understand, accept, and agree to this Financial Alliance.

_____ _____
Signature of Patient or Responsible Party **Date**

James L. Schumacher DMD - Schumacher Dental Center, PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
Signature {Date}

We send communications by text and email – please confirm your acceptance of this:

Yes or No to: _____ Email _____Text

Permission to share dental health information with _____

Permission to share my dental health info and dental insurance info with any referral offices.

By Phone: _____ By Email: _____ (please note yes or no)

By Email we will be sending records in an encrypted format. If the receiving party does not want to accept the encrypted format we will need your permission to send without.

For Office Use Only

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

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