

reception@schmittprosthodontics.com

LIMITED TO PROSTHODONTICS
the restoration & replacement of teeth

www.schmittprosthodontics.com

DATE: _____

LAST NAME: _____ FIRST: _____ M.I.: _____

PREFERS TO BE CALLED: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____

BIRTH DATE: _____ AGE: _____ MALE FEMALE

SOCIAL SECURITY: _____

E-MAIL ADDRESS: _____

OCCUPATION: _____ EMPLOYER'S NAME: _____

WORK ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: _____ WORK FAX: _____

REFERRED BY: _____

EMERGENCY CONTACT: _____ PHONE: _____

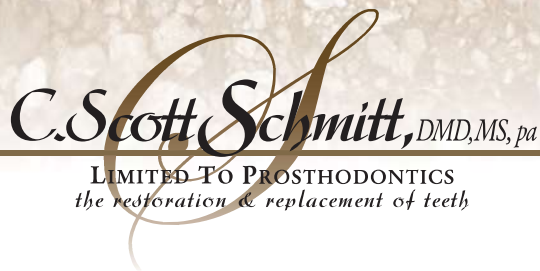
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I understand that this dental office does not accept direct billing from insurance companies.

PATIENT'S SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____



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- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| 1. Have you been under the care of a medical doctor during the past two years? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, for what? _____ | | |
| Physician's Name: _____ Phone: _____ | | |
| Address _____ City: _____ State: _____ Zip: _____ | | |
| 2. Have you taken any medication or drugs during the past two years? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication, drugs or pills now? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list names and dosage: _____ | | |
| 4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list: _____ | | |
| 5. Have you been a patient in the hospital during the past five years? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Indicate which of the following you have had, or have at present. Check YES or NO to each item. | | |

	YES	NO		YES	NO		YES	NO
Heart (Surgery, Disease, Attack).....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious) B Serum....	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	H.I.V. Positive.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses.....	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Fever Blisters.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve.....	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatism.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medicine.....	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hives.....	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
Diet (Special/Restricted).....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints (Hip, Knee, etc.)....	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Anxious.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Tumors.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/Psychological Care.....	<input type="checkbox"/>	<input type="checkbox"/>

- | | | |
|---|--------------------------|--------------------------|
| 7. Do you use more than two pillows to sleep?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you lost or gained more than 10 pounds in the past year?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have or have you had any disease, condition, or problem not listed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list: _____ | | |
| 10. Women Only: Are you..... | | |
| Pregnant? If YES, _____ Months..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking birth control pills?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Are you currently taking, or have taken in the past, any of the following medication?

	YES	NO
Fosamax & Binosto (Alendronate).....	<input type="checkbox"/>	<input type="checkbox"/>
Actonel & Atelvia (Risedronate).....	<input type="checkbox"/>	<input type="checkbox"/>
Skelid (Tiludronate).....	<input type="checkbox"/>	<input type="checkbox"/>
Boniva (Ibandronate).....	<input type="checkbox"/>	<input type="checkbox"/>
Aredia (Pamidronate).....	<input type="checkbox"/>	<input type="checkbox"/>
Zometa & Reclast (Zoledronate).....	<input type="checkbox"/>	<input type="checkbox"/>
Prolia & Xgeva (Denosumab).....	<input type="checkbox"/>	<input type="checkbox"/>
Sutent (Sunitinib).....	<input type="checkbox"/>	<input type="checkbox"/>
Nexavar (Sorafenib).....	<input type="checkbox"/>	<input type="checkbox"/>
Avastin (Bevacizumab).....	<input type="checkbox"/>	<input type="checkbox"/>
Rapamune (Sirolimus).....	<input type="checkbox"/>	<input type="checkbox"/>

Answer YES or NO to the following questions.
 If YES, rate on the scale of 0-3.

0=Never; 1=Slight; 2=Moderate; 3=High

	YES	NO
Snoring, interrupted by pauses in breathing (apnea).....	<input type="checkbox"/>	<input type="checkbox"/>
Excessive daytime sleepiness.....	<input type="checkbox"/>	<input type="checkbox"/>
Gaspings or choking while sleeping.....	<input type="checkbox"/>	<input type="checkbox"/>
Restless sleep.....	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual deterioration.....	<input type="checkbox"/>	<input type="checkbox"/>
Poor judgement/concentration.....	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Irritability.....	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high blood pressure).....	<input type="checkbox"/>	<input type="checkbox"/>
Nocturnal Angina (chest pain at night).....	<input type="checkbox"/>	<input type="checkbox"/>
Depression.....	<input type="checkbox"/>	<input type="checkbox"/>
Morning headaches.....	<input type="checkbox"/>	<input type="checkbox"/>

I understand the provided medical history information is necessary to provide me with dental care 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 changes in my health or medication.

PATIENT'S SIGNATURE: _____ **DATE:** _____

HISTORY REVIEW:

DENTIST'S SIGNATURE: _____ **DATE:** _____

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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? _____

Answer YES or NO to the following :

YES NO

PERSONAL HISTORY

- | | | |
|--|--------------------------|--------------------------|
| 1. Are you fearful of dental treatment? Scale of 1 to 10 (very)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or reactions to local anesthetic?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed?..... | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS

- | | | |
|---|--------------------------|--------------------------|
| 7. Is there anything about the appearance of your teeth that you would like to change?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever whitened (bleached) your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you self conscious about your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been disappointed with the appearance of previous dental work?..... | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT

- | | | |
|--|--------------------------|--------------------------|
| 11. Do you/would you have any problems chewing gum?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you/would you have any problems chewing bagels or other hard foods?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are you teeth crowded or developing spaces?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have any problems when you sleep or wake up with an awareness of your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have tension headaches or sore teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you wear or have you ever worn a bite appliance?..... | <input type="checkbox"/> | <input type="checkbox"/> |

TOOTH STRUCTURE

- | | | |
|--|--------------------------|--------------------------|
| 20. Have you had any cavities within the past 3 years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have a dry mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are any teeth sensitive to hot, cold, biting or sweets?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you avoid brushing any part of your mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you feel or notice any holes (i.e. pitting) in your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE

- | | | |
|---|--------------------------|--------------------------|
| 26. Have you ever been diagnosed or treated for periodontal (gum) disease?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you experienced gum recession?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Is there anyone with a history of periodontal disease in your family?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do your gums bleed when brushing, flossing or eating?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Are your teeth becoming loose?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever noticed an unpleasant taste or odor in your mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you experienced a burning sensation in your mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> |

PATIENT'S SIGNATURE: _____ PRINT: _____ DATE: _____

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may provide you with a report of your progress for your insurance company if applicable. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may provide you with appointment reminders such as postcards and/or a phone call. If you are not available, we may leave this information on your voicemail or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above mentioned normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. If this practice is sold, your information will become the property of the new owner. You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. You must provide us a written request detailing the specific information you require. If you also want a copy of your records, we may charge you a reasonable fee for the copies. You have the right to request an amendment or change to your health information. You must provide us with a written request detailing the specific information you are requesting. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice. Please note: You may refuse to sign this acknowledgment.)

ACKNOWLEDGMENT

I have received a copy of the Notice of Privacy Practices DATE: _____

PATIENT'S SIGNATURE: _____ PRINT: _____

If signing as a parent or guardian, please note the name of the patient: _____

Thank you, and if you have any questions about this form or the Privacy Practices, please contact our privacy officer.

OFFICE USE ONLY: As a privacy officer, I attempted to obtain the patient's (or representative's) signature on the Acknowledgment, but did not because _____. It was an emergency treatment, _____ I could not communicate with the patient, _____ The patient refused to sign, _____ The patient was unable to sign because _____ Other (please describe) _____

Signature of Privacy Officer

PHOTO RELEASE

I hereby authorize C. Scott Schmitt, DMD MS PA, to use photographs, x-rays or any other images of my likeness for educational or insurance claim documentation purposes. This permission includes unrestricted use of these images for the purpose of educating the public and/or dental professionals about dental treatment. This use may include display on the office website. In granting this permission, I understand that my name will not be revealed to the general public without my written permission.

PATIENT'S SIGNATURE: _____ PRINT: _____ DATE: _____