WELCOME

David A. Schimmel, DMD / 2013 Sandy Dr., State College, PA 16803 / (814) 234-8527 Fax (814) 234-1568 / www.smilesbyschimmel.com

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

NAME: _____ Mr. Mrs. Ms. Dr.

I prefer to be called: _____ Male ❑ Female ❑

Birthdate ____/____/____ Age: _____ SS# _____

Home Address: _____ Home #: _____

Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Work #: _____

Employer: _____ Cell #: _____

Whom may we thank for referring you? _____ E-mail #: _____

Previous/Past Dentist: _____ Last visit date: _____

Spouse/Guardian Name: _____

Home #: _____ Work #: _____ SS# _____

Address: _____ Birthdate: ____/____/____

INSURANCE INFORMATION

Primary Insurance:

Name of Insured _____ Employer _____

Group Number _____ ID # _____

Name of Insurance Company _____

Insurance Company Address _____

Secondary Insurance:

Name of Insured _____ Employer _____

Group Number _____ ID # _____

Name of Insurance Company _____

Insurance Company Address _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature Patient/Guardian _____ Date _____

Office Use: I verbally reviewed the medical/dental information above with the patient named herein. _____ _____

Initials Date

MEDICAL HISTORY

Physician's Name: _____ Phone #: _____ Date of last visit: _____

Please list any prescription/over the counter drugs/supplements being taken (including aspirin and vitamins): _____

_____

Are you currently under a physicians care? ❑ Yes ❑ No _____

For Women: Are you taking birth control pills? ❑ Yes ❑ No Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

Check if you have had any of the following diseases or medical conditions.

- ❑ Abnormal Bleeding
- ❑ Acid Reflux
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Artificial Valves
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally with Extractions or Surgery
- ❑ Blood Transfusion/Blood Disorder
- ❑ Cancer/Chemo/Radiation
- ❑ Circulatory Problems
- ❑ Congenital Heart Defect
- ❑ Cortisone Treatment
- ❑ Cough, Persistent or Bloody
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug/Alcohol Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Fever Blisters/Herpes
- ❑ GERD
- ❑ Headaches
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery/Problems
- ❑ Hemophilia
- ❑ Hepatitis type ____
- ❑ HIV/Aids
- ❑ Hospitalized for any Reason
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Psychiatric Problems
- ❑ Respiratory Disease
- ❑ Rheumatic/Scarlet Fever
- ❑ Seizures
- ❑ Shingles
- ❑ Sinus condition
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling, Feet/Ankles
- ❑ Swelling Neck Glands
- ❑ Tonsilitis
- ❑ Tuberculosis (TB)
- ❑ Ulcers/Colitis
- ❑ Venereal Disease (Chlamydia)

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to of the following?

- ❑ Aspirin
- ❑ Dental Anesthetics
- ❑ Latex
- ❑ Penicillin
- ❑ Codeine
- ❑ Erythromycin
- ❑ Metal
- ❑ Sulfa Drugs
- ❑ Tetracycline
- ❑ Amoxicillin
- ❑ Dyes
- ❑ Other _____

Please list any other drugs that you are allergic to: _____

_____

NOTES:

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