ROBERT SCHMIDT DMD

DATE _____

LAST NAME | DR., MR, MRS, MS. | FIRST NAME | MIDDLE

NAME YOU GO BY | NAME OF SPOUSE

HOME ADDRESS | CITY | STATE / ZIP | CELL/ HOME PHONE NO.

EMPLOYER | BUSINESS ADDRESS | OFFICE PHONE NO. | SOCIAL SECURITY NO.

EMAIL _____

1. **WHO MAY WE THANK FOR REFERRING YOU?** _____
2. **WHAT IS YOUR PRESENT DENTAL CONCERN?** _____

DENTAL HISTORY

1. **HAVE YOU LOST ANY OF YOUR NATURAL TEETH?** ❑ YES ❑ NO HOW? _____
2. **HAVE THEY BEEN REPLACED?** ❑ YES ❑ NO HOW? _____
3. **DATE AND TYPE OF LAST DENTAL X-RAYS?** _____
4. **HOW WOULD YOU RATE YOUR PRESENT DENTAL HEALTH?** ❑ EXCELLENT ❑ GOOD ❑ POOR
5. **HOW WOULD YOU LIKE TO RATE YOUR FUTURE DENTAL HEALTH?** ❑ EXCELLENT ❑ GOOD ❑ POOR
6. **ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH?** ❑ YES ❑ NO ❑ IF NOT, WHY? _____

7. HAVE YOU NOTICED:	YES	NO
A. GROWTHS, SWELLING, SORE SPOTS	❑	❑
B. PAIN OR TENDERNESS IN YOUR TEETH	❑	❑
C. BLEEDING GUMS	❑	❑
D. SENSITIVE TEETH	❑	❑
E. FOOD CATCHING BETWEEN TEETH	❑	❑
F. BAD BREATH	❑	❑

8. GENERAL DENTAL INFORMATION:	YES	NO
A. HAVE YOU BEEN SHOWN HOW TO FLOSS YOUR TEETH?	❑	❑
B. HAVE YOU BEEN TREATED FOR GUM DISEASE?	❑	❑
C. HAVE YOU HAD BRACES TO STRAIGHTEN YOUR TEETH?	❑	❑
D. DO YOU HAVE DIFFICULTY IN SWALLOWING?	❑	❑

9. PROBLEMS WHICH MAY BE RELATED TO YOUR OCCLUSION (BITE) OR JAW JOINT. HAVE YOU HAD, OR BEEN AWARE OF:

A. TIRED FEELING IN FACE WHILE CHEWING	❑	❑	D. CLENCHING OR GRINDING YOUR TEETH	❑	❑
B. RINGING OR PAIN IN EAR	❑	❑	E. HEADACHES	❑	❑
C. PAIN AROUND EARS, EYES, NECK, HEAD	❑	❑	F. POPPING NOISES IN THE JAW JOINT	❑	❑

10. **WHICH ITEMS DO YOU USE REGULARLY?** ❑ HAND TOOTHBRUSH ❑ DENTAL FLOSS ❑ ELECTRIC TOOTHBRUSH ❑ WATER SPRAY ❑ TOOTHPICKS, STIMULATORS , ETC. ❑ RUBBER TIP ❑ Other _____
11. **HAVE YOU HAD ANY UNFAVORABLE DENTAL EXPERIENCES?** ❑ YES ❑ NO _____
12. **DO YOU DESIRE TO MAINTAIN YOUR OWN TEETH AND AVOID DENTURES AS LONG AS POSSIBLE?** ❑ YES ❑ NO
13. **HOW IMPORTANT IS IT TO YOU TO KEEP YOUR NATURAL TEETH?**

VERY IMPORTANT 10 9 8 7 6 5 4 3 2 1 NOT IMPORTANT AT ALL

MEDICAL HISTORY

FAMILY PHYSICIAN SPECIALTY ADDRESS TELEPHONE

HEIGHT_____ WEIGHT_____ AGE_____ DATE OF BIRTH _____

DATE OF LAST MEDICAL EXAM _____(MONTH / YEAR)

1. **HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH?** ❑ POOR ❑ FAIR ❑ GOOD
2. **HOW WOULD YOU DESCRIBE YOUR DIET?** ❑ POOR ❑ FAIR ❑ GOOD
3. **DO YOU EXERCISE REGULARLY?** ..... ❑ YES ❑ NO
4. **DO YOU SMOKE?** ..... ❑ YES ❑ NO **IF YES, DOES IT CONCERN YOU?** ..... ❑ YES ❑ NO
5. **DO YOU TAKE MORE THAN ONE ALCOHOLIC DRINK PER DAY?** ❑ YES ❑ NO
6. **ARE YOU NOW BEING TREATED OR HAVE YOU BEEN TREATED WITHIN THE LAST YEAR BY A PHYSICIAN?** ❑ YES ❑ NO
   FOR WHAT? .....
7. **HAVE YOU EVER HAD AN UNUSUAL REACTION TO DENTAL ANESTHESIA (GAS OR SHOTS)?** ❑ YES ❑ NO
8. **FOLLOWING INJURIES OR DENTAL TREATMENT, HAVE YOU HAD BLEEDING PROBLEMS?** ❑ YES ❑ NO
9. **IS THERE A HISTORY OF DIABETES IN YOUR FAMILY?** ❑ YES ❑ NO
10. **ARE YOU THIRSTY MOST OF THE TIME?** ..... ❑ YES ❑ NO
11. **HAVE YOU RECENTLY LOST OR GAINED WEIGHT UNINTENTIONALLY?** ..... ❑ YES ❑ NO
12. **IF DIAGNOSED AS A DIABETIC, ARE YOU CURRENTLY TAKING MEDICATION?** ..... ❑ YES ❑ NO

HAVE YOU BECOME SICK FROM, SHOWN AN ALLERGY TO, OR BEEN TOLD NOT TO TAKE:

13. ❑ ANTIBIOTICS (penicillin , etc.)
14. ❑ CODEINE
15. ❑ NOVOCAINE OR OTHER DENTAL ANESTHESIA
16. ❑ OTHER DRUGS OR MEDICINES_____

ARE YOU NOW TAKING OR USING MEDICINE FOR:

17. ❑ NERVES (tranquilizers)
18. ❑ SLEEPING
19. ❑ HEART OR BLOOD PRESSURE (digitalis, nitroglycerin, reserpine)
20. ❑ BLOOD (liver or iron pills, etc.)
21. ❑ STOMACH TROUBLE (ulcer or other)
22. ❑ HEADACHES
23. ❑ ARTHRITIS OR RHEUMATISM
24. ❑ ALLERGY

ARE YOU NOW:

25. ❑ PREGNANT
26. ❑ ON A PRESCRIBED DIET
27. ❑ USING THYROID MEDICATION
28. ❑ USING HORMONES (including birth control pills)
29. ❑ USING ANTICOAGULANTS
30. ❑ USING DILANTIN
31. ❑ USING OTHER MEDICINES_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

32. ❑ HEART DISEASE
33. ❑ SHORTNESS OF BREATH WITHOUT EXERCISE OR WHEN LYING DOWN
35. ❑ SWELLING OF ANKLES OR FEET
36. ❑ PAIN, PRESSURE, OR TIGHT FEELING IN CHEST
37. ❑ HEART ATTACK
38. ❑ MITRAL VALVE PROLAPSE
39. ❑ RHEUMATIC FEVER
40. ❑ HIGH BLOOD PRESSURE
41. ❑ FAINTING SPELLS, CONVULSIONS, EPILEPSY
42. ❑ FREQUENT HEADACHES (two or three a week)
43. ❑ NERVOUS BREAKDOWN, PSYCHOTHERAPY
44. ❑ LUNG TROUBLE (TB, asthma, emphysema)
45. ❑ HEPATITIS, LIVER DISEASE, JAUNDICE
46. ❑ ACQUIRED IMMUNODEFICIENCY SYNDROME
47. ❑ ARTHRITIS, SORE JOINTS
48. ❑ EXCESSIVE BLEEDING
49. ❑ BLOOD TROUBLE, ANEMIA, LEUKEMIA
50. ❑ X-RAY, RADIUM OR COBALT TREATMENTS
51. ❑ JOINT REPLACEMENTS

_____

SIGNATURE DATE

FOR OFFICE USE ONLY _____

MEDICAL HISTORY

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SIGNATURE DATE

FOR OFFICE USE ONLY _____

Dr. Robert L. Schmidt, DMD PLLC

Authorization for Release of Information - Compound Release

Name of Patient_____Date of Birth_____

Robert L. Schmidt, DMD PLLC is authorized to release protected health information about above named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information. Check the type of information that can be given to person/entity on the left in the same section.	
□ Voice Mail	□ Results of lab tests/x-rays □ Other_____
□ Other persons(provide name and phone number)	□ Financial □ Medical
□ Email communication Provide email address below _____ For email communication to occur please accept the disclosure below.	□ Financial □ Medical □ Appointment reminders □ Breach notification
□ Text communication Number_____ For text communication to occur please accept disclosure below.	□ Appointment reminder □ Other_____
□ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
□ Photo Release Photo taken by staff may be posted in office or on website.	

Patient rights:
I have the right to revoke this authorization at any time
I may inspect or copy the protected health information to be disclosed as described in this document
Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law
I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This Authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative.

Dr. Robert L. Schmidt, DMD PLLC

Dedicated to Health Centered Dentistry

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address:_____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____

_____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  _____
- ☐ Other: _____

  _____

Prepared By _____

Signature _____

Date _____