Schneider Family Dentistry
New Patient Form

Patient Name _____ Date of Birth _____

Nickname _____ Gender _____

Main Language _____ Marital Status _____

Who may we thank for referring you to our practice? _____

CONTACT INFORMATION

Email _____ Home Phone _____

Cell Phone _____ Work Phone _____

Home Address _____ Emergency Contact _____

_____ Emergency Phone _____

_____ Preferred Pharmacy _____

_____ Pharmacy Phone # _____

Occupation _____

Employer _____

If someone other than the patient schedules appointments and/or pays bills, please complete the following:
Responsible Party (pays bills)

Name _____ Relationship _____

Email _____

Phone _____

Head of Household (makes appts)

Name _____ Relationship _____

Email _____

Phone _____

If patient is a minor, please complete the following:

Guardian Name _____ Relationship _____

Email _____ Address _____

Mobile Phone _____ _____

Home Phone _____ _____

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INSURANCE

Please complete this section IF you have dental insurance

Primary Insurance Company

Group # _____ Policy Holder _____

Policy/ID # _____ Policy Holder DOB _____

Relationship to

Phone # _____ Patient _____

Address _____ SSN _____

_____

Secondary Insurance Company (optional)

Group # _____ Policy Holder _____

Policy/ID # _____ Policy Holder DOB _____

Relationship to

Phone # _____ Patient _____

Address _____ SSN _____

_____

DENTAL HEALTH	Yes	No
Do your gums bleed when you brush or floss?	Yes	No
Have you ever had orthodontic treatment (e.g., braces or invisalign)?	Yes	No
Have you had any periodontal (gum) treatment?	Yes	No
Have you had any problems associated with previous dental treatment?	Yes	No
Is your home water supply fluoridated?	Yes	No
Do you grind your teeth?	Yes	No
Do you snore?	Yes	No
Do you have any clicking or discomfort in your jaw?	Yes	No
Have you ever had a serious injury to your head, neck, or mouth?	Yes	No
Are you currently experiencing dental pain or discomfort?	Yes	No
Are your teeth sensitive to cold, hot, sweets or pressure?	Yes	No
Do you have earaches or neck pains?	Yes	No
Do you have any sores or ulcers in your mouth?	Yes	No

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ALLERGIES

Acetaminophin (Tylenol)	YES	NO	Ibuprofen (Advil)	YES	NO	Penicillin	YES	NO
Acrylic	YES	NO	Iodine	YES	NO	Seasonal Allergies	YES	NO
Aspirin	YES	NO	Latex	YES	NO	Sulfa	YES	NO
Codeine	YES	NO	Local Anesthetic	YES	NO	Tetracycline	YES	NO
Demerol	YES	NO	Metals	YES	NO	Other		
Erythromycin	YES	NO	Mint	YES	NO			
Fluoride	YES	NO	Penicillin	YES	NO			

Please describe reactions you have to indicated allergens _____

CONDITIONS - Please indicate if you have or have had any of the following:

			HEART CONDITIONS			**NEUROLOGICAL CONDITIONS**		
Back Problems	YES	NO	Angina	YES	NO	Alzheimer's/Dementi	YES	NO
Chronic Pain	YES	NO	Arteriosclerosis	YES	NO	Anxiety	YES	NO
Hearing Difficulties	YES	NO	Cardiovascular Disease	YES	NO	Dizziness	YES	NO
Jaundice	YES	NO	Chest Pain with Exercise	YES	NO	Epilepsy	YES	NO
Other	YES	NO	Congenital Heart Defect	YES	NO	Fainting Spells or Sei	YES	NO
Persistent Swollen Glands	YES	NO	Congestive Heart failure	YES	NO	Frequent Headaches	YES	NO
Recurrent Infections	YES	NO	Damaged Heart Valves	YES	NO	Memory Issues	YES	NO
Severe Or Rapid Weight Loss	YES	NO	Heart Attack	YES	NO	Mental Disorder	YES	NO
Thyroid Condition	YES	NO	Heart Surgery	YES	NO	Migraines	YES	NO
TMJ Disorder	YES	NO	High Blood Pressure	YES	NO	Psychiatric Care	YES	NO
Tumors	YES	NO	Low Blood Pressure	YES	NO	Severe Headaches	YES	NO
Ulcers	YES	NO	Pacemaker	YES	NO	Stroke	YES	NO

DISEASES			**DENTAL CONDITIONS**			**BLOOD CONDITIONS**		
AIDS or HIV	YES	NO	Bulimia	YES	NO	Anemia	YES	NO
Sexually Transmitted Infection	YES	NO	Dental Anxiety	YES	NO	Blood Disorder	YES	NO
Veneral Disease	YES	NO	Difficult to Numb	YES	NO	Blood Transfusion	YES	NO
Hepatitis	YES	NO	Fear of Needles	YES	NO	Excessive Bleeding	YES	NO
Tuberculosis	YES	NO	Nervous Disorder	YES	NO	Hemophilia	YES	NO
Kidney Disease	YES	NO						
Liver Disease	YES	NO	**RHEUMATOID CONDITIONS**			**RESPIRATORY CONDITIONS**		
Multiple Sclerosis	YES	NO	Osteoporosis/Paget's Disease	YES	NO	Asthma	YES	NO
Diabetes	YES	NO	Rheumatic Heart Disease	YES	NO	Breathing Problems/I	YES	NO
Cancer	YES	NO	Rheumatism	YES	NO	Bronchitis	YES	NO
Autoimmune Disease	YES	NO	Rheumatoid Arthritis	YES	NO	Emphysema	YES	NO
Autoimmune Disorder	YES	NO	Swollen Joints	YES	NO	Sinus Problems	YES	NO
Systemic Lupus Erythematosus	YES	NO						

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CONDITIONS, CONTINUED

PHYSICAL CONDITIONS	YES	NO
Physical Challenges	YES	NO
Wheelchair Access	YES	NO

FEMALE PATIENTS

Are you pregnant	YES	NO

SOCIAL CONDITIONS		
Alcohol Consumption	YES	NO
IV Drug Use	YES	NO
Tobacco Use	YES	NO
Tattoos	YES	NO
Nicotine Supplements	YES	NO
Vaping	YES	NO

GI CONDITIONS		
Reflux/Heartburn	YES	NO
GI Disease	YES	NO
Celiac Disease	YES	NO

OTHER _____

Has there been any change to your general health within the past year?	YES	NO
Have you recently had a blood transfusion?	YES	NO
Do you have issues with severe coughing?	YES	NO
Have you had an HPV Vaccination?	YES	NO
Have you had a serious illness, surgery, or been hospitalized in the	YES	NO
Have you ever reacted adversly to any medications or injections?	YES	NO
Have you had an orthopedic joint replacement?	YES	NO

MEDICATIONS

_____ **I am not currently taking any prescription or over-the-counter medications.**

_____ **I am currently taking the following prescription and over-the-counter medications:**

Antibiotics _____

Birth Control _____

Blood Pressure Medication _____

Blood Thinner _____

Chemotherapy _____

Radiation _____

Steroid/Hormone Treatment _____

Vitamins _____

Other _____

Other _____

Other _____

Other _____

Other _____

Please list additional medications here:

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The doctors at Schneider Family Dentistry ask your cooperation with the following:

1. Notify us promptly of any change in your address or insurance information.
2. You are responsible for all charges for services provided. We expect payment at the time of your visit for all charges owed for that visit as well as any prior balance. If you have insurance, co-payments must be made at the time services are rendered and we will submit a claim on your behalf. You are responsible for charges not covered by your insurance
3. Know your insurance policy. Every policy has its own rules and regulations, and it is in your best interest to know what your policy covers and if referrals are required.
4. We use Xrays to monitor your dental health, diagnose problems, and plan appropriate treatments. Our xrays emit low levels of radiation. If you refuse xrays, we may not be able to properly and fully diagnose dental issues. We may terminate you as a patient if you refuse to have diagnostic xrays.
5. All appointments must be scheduled in advance. A $50 no-show or late cancellation fee will be apply if you do not come to your appointment or if you do not cancel your appointment at least 24 hours in advance.
6. Accounts not paid within 90 days after the date of an invoice may be referred to a collection agency for collection. You agree to pay an additional $25 collection fee if your account is referred for collection.
7. If your payment is dishonored or returned for any reason, we may electronically debit you account for the amount of the payment plus a processing fee of $35.
8. If you need a prescription refill or referral request, please allow 48 hours form the time of your call to process your

My signature below certifies that the information I have provided above is correct and accurate to the best of my knowledge. If the patient is a minor, the form must be signed by the parent or guardian.

_____

Signature Date

_____

Print Name

Please be sure to review and acknowledge our privacy practices and to tell us your authorized contacts and preferred methods of communication. These are on separate forms to be filled out.