WELCOME TO THE OFFICE

PAUL SCHWARTZ D.D.S.

Contact Information

Patient Name: ______________________ Birth Date: ______________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: ______________

Address: ____

Street City State Zip Code

Phone (Home): ____________ (Work): __________ Ext: ______ (Cell): ______________

Emergency Contact: ____________ Relationship: __________ Phone ______________

Employer Name: ______________________ Occupation: ______________________

Address: ____

Street City State Zip Code

Spouse or Responsible Party Information

Name: ____

☐ Male ☐ Female Relationship to Patient ______________________

Social Security #: ______________________ Birth Date: ______________

☐ Address Same as Above ☐ Phone Same as Above

Address: ____

Street City State Zip Code

Phone (Home): ____________ (Work): __________ Ext: ______ (Cell): ______________

Insurance Information

Primary

Name of Insured: ☐ Patient ☐ Spouse or Responsible Party

☐ Other: ____

Name Birth Date Relationship

Insurance Plan: ____________ ID #: ____________ Group #: ______________

Insurance Address: ____

Street City State Zip Code

Employer Name: ____

Employer's Address: ____

Street City State Zip Code

Secondary

Name of Insured: ☐ Patient ☐ Spouse or Responsible Party

☐ Other: ____

Name Birth Date Relationship

Insurance Plan: ____________ ID #: ____________ Group #: ______________

Insurance Address: ____

Street City State Zip Code

Employer Name: ____

Employer's Address: ____

Street City State Zip Code

Health Information

Date of Last Dental Visit: ______________________ Reason for this visit: ______________________

How often do you floss?: ______________________ How often do you brush?: ______________________

Do you have any of the following? Please check those that apply:

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Arthritis
- ☐ **Artificial Joints**
- ☐ **Artificial Heart Valve**
- ☐ Asthma
- ☐ Birth Control Pills
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ **Mitral Valve Prolapse**
- ☐ Nursing
- ☐ **Pacemaker**
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swelling of Feet
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

• Are you required to take **PREMEDICATION**? ☐ No ☐ Yes: ______________________

• Please list all **MEDICATIONS** you are currently taking: ______________________

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• Please list all **ALLERGIES**: ______________________

• Have you ever had any serious illnesses or operations? ☐ No ☐ Yes: ______________________

• Do you have any health problems that need further clarification? ☐ No ☐ Yes: ______________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ______________

Signature of patient, parent or guardian

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________________

Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________________

Signature of guarantor of payment/responsible party