

Canton Dental Clinic

Dr. Gordon Schulte Dr. Melissa Brandner Dr. Dane Steffen

Patient Information

Date _____ Patient's Name _____
_____ Age _____ Sex: M F
_____ Last _____ First _____ Middle _____
Mailing Address _____ How long at this address? _____
Street City State Zip
Home Phone (____) _____ **Cell Phone** (____) _____ Birthdate _____ Social Security # _____
Employer _____ Occupation _____ **Work Phone** (____) _____ School _____
Spouse's Name _____ Birthdate _____ Social Security # _____
Employer _____ Occupation _____ **Work Phone** (____) _____
Whom may we thank for referring you? _____

Responsible Party Information (If parent is responsible for account)

Father's Name _____ Birthdate _____ Social Security # _____
Address _____ Home Phone (____) _____
Employer _____ Occupation _____ Work Phone (____) _____
Mother's Name _____ Birthdate _____ Social Security # _____
Address _____ Home Phone (____) _____
Employer _____ Occupation _____ Work Phone (____) _____

Do you have Dental Insurance? Yes No

Primary Insurance Company: Do you have dual coverage? Yes No If yes:
Subscriber's Name _____ Subscriber's Name _____
Subscriber's Address _____ Subscriber's Soc. Sec. # _____
Subscriber's Soc. Sec. # _____ Insurance Company _____
Insurance Company _____ Group No. _____ ID No. _____
Group No. _____ ID No. _____ Ins. Co. Address _____
Insurance Co. Address _____ Telephone (____) _____
Telephone (____) _____ Subscriber's Employer/Address _____
Subscriber's Employer/Address _____
Is patient covered under Medicaid? # _____
I have read and answered all questions to the best of my knowledge. I authorize and

Authorization and Release

request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. I understand that where appropriate, credit bureau reports may be obtained.

Signature of patient (or parent if minor) _____ **(required)** Date _____

Preferred Method of Payment: cash check credit card

Payment is due in full at time of treatment unless prior arrangements have been approved. 5% cash discount (over please)

Please complete if you are a "new" patient

Reason for today's visit _____ _____ Former Dentist _____ City/State _____ Date of last dental visit _____ For what service? _____ Date of last dental X-rays _____	Place a mark "Yes" or "No" to indicate if you have had any of the following: Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No Smoking/tobacco habit <input type="checkbox"/> Yes <input type="checkbox"/> No Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No How often do you floss? _____ How often do you brush? _____ Do you drink purified water? _____
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Medical History

Physician's Name _____	Date of last visit _____	
Have you had any serious illnesses or operations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe _____		
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give approximate dates _____		
Have you ever been told you cannot give blood? _____ Reason _____		
(Women) Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No Taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No		
AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal bleeding from a cut <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No Cough, Persistent <input type="checkbox"/> Yes <input type="checkbox"/> No Cough up Blood <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Describe _____ Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis -Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No Swelling of Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco Habit <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis/TB <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No

Medications

List medications you are currently taking: _____ _____ _____ Pharmacy Name _____ Phone _____
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Allergies

<input type="checkbox"/> Aspirin <input type="checkbox"/> Barbiturates (Sleeping Pills) <input type="checkbox"/> Codeine <input type="checkbox"/> Iodine <input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____
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Emergency Information

Name of nearest relative not living with you _____ Phone _____ _____

Future Updates: Signature _____ Date _____ Signature _____ Date _____