

Date: \_\_\_\_\_

Chart: \_\_\_\_\_  
For office use only

Whom may we thank for referring you to our practice? \_\_\_\_\_

### Patient Information

Patient Name: \_\_\_\_\_  
Last First MI Preferred Name

(Please circle): Gender: F M Marital Status: Single Married Other Child

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Ext.) \_\_\_\_\_ (Cell) \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street Apartment #

City State Zip

Email Address: \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### Spouse or Responsible Party Information

The following information is for the: \_\_\_\_\_ patient's spouse or responsible party \_\_\_\_\_ parent or legal guardian

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Dr. License # \_\_\_\_\_  
Last First MI

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer Phone # \_\_\_\_\_ Address: \_\_\_\_\_

### Primary Dental Insurance Information

Name of Insured: \_\_\_\_\_ Is Insured a patient? Yes \_\_\_\_\_ No \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip

Insured's Employer: \_\_\_\_\_ Patient's Relation to Insured: \_\_\_\_\_  
Self, Spouse, Child, Other

Insurance Plan Name and Address: \_\_\_\_\_

#### For patients with insurance coverage:

- Patients who carry dental insurance understand that all dental services are charged directly to the patient and they are responsible for payment of all dental services. As a service, this office will help in the preparation of the dental insurance forms or assist in making collections from the insurance company. When applicable, insurance payments will be assigned to this office and will be credited to the patient's account. I understand this office cannot render services on the assumption that fees will be paid by my insurance company and I will be responsible for any fees not covered by my insurance company.
- I agree to inform this office of any and all changes regarding my dental insurance coverage prior to claims filed by this office.

#### To release information to your insurance company and assign insurance benefits to this office, please read and sign the following:

- I shall review the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with the claim.

#### Signature of patient, parent or guardian

- As the employee or subscriber to the above dental insurance, I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr. Mitschke or his assignee.

Signature of employee or subscriber: \_\_\_\_\_ Date: \_\_\_\_\_

### Health Information Update

Date of your last dental visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

Please check the following health issues that apply to your personal health:

Anesthesia Allergy  
 Codeine Allergy  
 Penicillin Allergy  
 Other Allergies \_\_\_\_\_

Anemia  
 Arthritis  
 Artificial Joints  
 Asthma  
 Blood Disease  
 Cancer  
 Cholesterol Imbalance  
 Depression  
 Diabetes  
 Dizziness  
 Epilepsy  
 Excessive Bleeding  
 Fainting  
 Glaucoma  
 Hay Fever

Heart disease  
 Heart Murmur  
 Hepatitis  
 Herpetic Lesions  
 High Blood Pressure  
 HIV/AIDS  
 Jaundice  
 Kidney Disease  
 Liver Disease  
 Mental Disorders  
 Mitral-Valve Disorders  
 Nervous Disorders  
 Pacemaker  
 Radiation  
 Respiratory Problems  
 Rheumatic Fever  
 Rheumatism  
 Sinus Problems  
 Stomach Problems  
 Stroke

Thyroid disorders  
 Tuberculosis  
 Tumors  
 Ulcers  
 Venereal Disease

Do you smoke or use other forms of tobacco? Y / N

Are you currently pregnant? Y / N

Due Date: \_\_\_\_\_

Is snoring or sleep apnea a problem for you? Y / N

Are there any other health issues that we need to be aware of, such as the need for pre-medication? Y / N

Please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Have you ever had a history of drug dependency?  Yes  No
- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Do you have a family history of periodontal disease?  Yes  No
- List any and all medications you are currently taking on a regular basis (prescription/over the counter).

- Are you currently taking a blood thinner?  Yes  No.

If yes, name of medication: \_\_\_\_\_

- Are you currently taking or have you ever taken bisphosphonates for osteoporosis?  Yes  No.

If yes, name of medication: \_\_\_\_\_

- Are you currently under the care of a physician?  Yes  No. If yes, Please explain: \_\_\_\_\_

- Name of physician: \_\_\_\_\_

To the best of my knowledge, all the preceding answers and information provided are true and correct. I understand that if there are any changes to my health history I will inform the doctor and staff at my next appointment without fail.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient, parent or legal guardian

### Consent for Services

**I am aware of the following and consent to services provided by this office under the conditions listed below:**

- As a condition of this office, all services are payable at the time that they are rendered, unless arrangements have been made prior to the appointment.
- Fee estimates for dental care prescribed by Dr. Mitschke can only be extended for a period of three months from the date of patient examination.
- A service charge of 1-1/2% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.
- I agree to pay the reasonable value of services provided by Dr. Mitschke or his assignee at the time services are rendered or within five (5) days of billing if credit shall be extended.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient, parent or legal guardian

Relationship to patient: \_\_\_\_\_