Schoepflin DENTAL EXCELLENCE

6500 SE MILE HILL DR. PORT ORCHARD 98366 (360)871-2959

Guest Information

Name _____ M/F DOB:____/____/____ SS # ____-____-____

Address _____City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email address _____

Please circle primary contact above (for making and confirming appointments.)

Spouse/Parent/Guardian Name _____ Contact #: _____

Employment Information

Person responsible for payment (circle one): PATIENT SPOUSE PARENT GUARDIAN

Employer: _____Address (city/state):_____

Emergency Contact Name and Number _____
Relationship_____

Insurance Information

Dental Insurance Program _____ Subscriber SS # _____

Subscriber Name _____ Group Number _____

Subscriber Address (if different from above) _____

Subscriber Employer _____ Subscriber Birth date _____

Secondary Insurance Program _____ Subscriber SS # _____

Subscriber Name _____ Group Number _____

Subscriber Employer _____ Subscriber Birth date _____

Medical History

Physician _____ Office phone _____ Last Visit _____

Have you had a severe illness or been hospitalized in the last five years? **Y / N** Date_____
Reason: _____

Have you ever taken: Phen-Fen/Redux/Pondimin? **Y / N** Bisphosphonates (i.e. Fosamax)? **Y / N**

Have you been told you need pre-medication for dental visits? **Y / N** Reason: _____
Physcian:_____

Have you ever had an adverse reaction during or in conjunction with a medical or dental procedure?
Y / N _____

Please list surgeon and phone number for all medical procedures:

_____

Please list all allergies to medications, local anesthetics, metals, latex, food, etc.

Please list all medications you are currently taking:

Medication	*Dosage*	*Reason*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle or check mark which of the following apply to the patient.

Advil (on regular basis)
Alcohol abuse/substance abuse
Anesthetic concerns
Anti-Inflammatory drugs
Arthritis
Aspirin (daily)
Asthma-inhaler needed?
Bad dental experience
Cancer---Radiation---Chemo dates:_____
Cannabis use- Form:_____ Frequency:_____ Last used:_____
Blood thinners, which one?_____
Diabetes
Epilepsy/seizures
Multiple Sclerosis
Pacemaker
PREMED for dental treatment
Wheelchair/mobility difficulties
Other: _____

Glaucoma
Heart disease
Heart attack
Heart murmur
Heart problems-Nitro tabs needed?
Hepatitis
High or Low blood pressure
HIV/AIDS
Mental disorders
Morphine (on regular basis)
Respiratory problems-inhaler needed?
Sinus problems
Tuberculosis
Thyroid problems
Tobacco use-frequency: _____
Excessive bleeding

Women Only:
Are you or might you be pregnant? **Y / N** Due Date: _____
Are you nursing? Y / N Are you taking any contraceptives/hormones? **Y / N**

Dental Health

Do you have frequent headaches or neck aches? Y / N
Location _____
Typical time of day _____
Frequency _____
Usual duration _____

Have you ever had any head, neck, or jaw injuries? Y / N
_____ _____

Do you clench or grind your teeth? Y / N _____ Do you wear a night guard? Y/N

Are there any other concerns regarding your teeth you would like to discuss with the dentist or hygienist?_____
_____
_____

We are committed to providing the highest quality dental care to all our guests. In return we ask that you extend the courtesy of notifying our office 48 hours in advance if you are unable to make your appointment. Missed appointments and short notice cancellations raise costs and inconvenience other guests in urgent need of dental care. Failure to make your scheduled appointment may result in a missed appointment fee of $50.00. Initials_____

I understand that I am responsible for my entire balance regardless of insurance coverage and my estimated portion of payment is expected at or before time of treatment.

Printed Name:_____

Signature: _____

Date: _____