CANYON LAKE
FAMILY & COSMETIC
DENTISTRY
REFRESH | RENEW | RESTORE

Today's Date: _____

Patient's Name: _____ Preferred Name: _____

Birthdate: _____ Age: _____ Circle One: S M C Widow Sex: Male Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Text: Yes No

SS# _____ DL# _____ Email: _____

Employer: _____ Work Phone: _____

Name/Phone of Responsible for account: _____

Spouse/Parent if Minor: _____ Spouse/Parent's Phone #: _____

Spouse/Parent's Employer: _____ Spouse/Parent's SS#: _____

EMERGENCY INFO: Name, Address, & Phone #

_____

Reason for this visit: _____

How did you hear about the office? _____

Front desk use: _____ Initial to indicate reviewing of no cleaning on NP Visit.

PATIENT NAME: _____

DENTAL HISTORY

Please check any of the following problems that apply:

- ❑ Sensitivity (hot,cold,sweet)
- ❑ Tooth pain or discomfort when chewing
- ❑ Headaches, ear aches, neck pain
- ❑ Mouth ulcers or cold sores
- ❑ Jaw joint pain
- ❑ Broken tooth or fillings
- ❑ Grinding or clenching teeth
- ❑ Bleeding, swollen or irritated gums
- ❑ Bad breath or bad taste in your mouth
- ❑ Do you snore?
- ❑ Have you been diagnosed with sleep apnea?
- ❑ Do you currently use a sleep appliance?
- ❑ Are you dissatisfied with your teeth and their appearance?
- ❑ Are you concerned about the finances required to return your teeth to excellent dental health?

Please circle one:

Do you smoke or use chewing tobacco?

How much? For how long?

_____

Please share the following dates:

Your last cleaning ____/____

Your last complete x-rays ____/____

If you could change your smile, you would:

- ❑ Make my teeth straighter
- ❑ Make my teeth whiter
- ❑ Close spaces
- ❑ Replace metal fillings with tooth colored fillings
- ❑ Repair chipped/missing teeth
- ❑ Replace old crowns that don't match
- ❑ Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?	1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?	1 2 3 4 5 6 7 8 9 10
What would you rate your anxiety/nervousness with dental treatment?	1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

What is the most important thing to you about your dental visit today?

_____

PLEASE FILL BACK OUT

MEDICAL HISTORY

Height:_____

Weight:_____

Please Circle any that apply for you:

Allergies (seasonal)	Heart Condition	Respiratory Problems
Anemia	Heart Murmur	Rheumatic Fever
Artificial Heart Valve	Hep A	Seizures
Artificial Joints	Hep B	Stroke
Asthma	Hep C	Thyroid Disease
Blood Disease	High Blood Pressure	Tuberculosis
Cancer	HIV/AIDS	Ulcers
Diabetes	Kidney Disease	Sleep Apnea
Dizziness/Fainting	Liver Disease	Prolonged Bleeding
Glaucoma	Radiation (head/neck)	Fever Blisters
Cold Sores	Snoring/Poor Sleep Quality	

OTHER:

_____

FOR WOMEN ONLY:

Birth Control Pills Breastfeeding Pregnant: 1-3mos 3-6mos 6-9mos

Do you have an allergy to any of the following?

Aspirin Codeine Penicillin Local Anesthetic Nitrous Oxide

Other Allergies: _____

If yes, please list your reactions:

_____

_____

Are you under a physician's care? For what?

_____

_____

_____

Please list current meds:

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____

FAMILY & COSMETIC DENTISTRY

PRIMARY INSURANCE INFORMATION

NAME OF INSURED: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

NAME OF INSURANCE COMPANY:

_____

SS# OR IDENTIFICATION # _____ GROUP # _____

EMPLOYER: _____ WORK PHONE: _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

NAME OF INSURANCE COMPANY:

_____

SS# OR IDENTIFICATION # _____ GROUP # _____

EMPLOYER: _____ WORK PHONE: _____

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER. WE ARE NOT A PARTY TO THIS CONTRACT, NOR CAN WE BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE REGARDING DEDUCTIBLES, COVERED CHARGES OR "USUAL AND CUSTOMARY" FEES. OUR INVOLVEMENT WILL BE LIMITED TO SUPPLYING FACTUAL INFORMATION TO FACILITATE CLAIMS PROCESSING FOR YOUR ACCOUNT.

IF INSURANCE HAS NOT MADE PAYMENT TO YOUR ACCOUNT IN 45 DAYS, WE AS THAT YOU CONTACT YOUR INSURANCE CARRIER AND MAKE PAYMENT TO OUR OFFICE FOR THE OUTSTANDING BALANCE.

I, THE UNDERSIGNED ASSIGN DIRECTLY TO DR. SCHAACK ALL BENEFITS. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC. I ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES NOT COVERED BY INSURANCE.

DATE: _____ SIGNATURE: _____

MINOR/CHILD CONSENT

I, BEING THE PARENT OR GUARDIAN OF _____ DO HEREBY REQUEST AND AUTHORIZE THE DENTAL STAFF TO PERFORM NECESSARY DENTAL SERVICE FOR MY CHILD, INCLUDING BUT NOT LIMITED TO X-RAYS, AND ADMINISTRATION OF ANESTHETICS WHICH ARE DEEMED ADVISABLE BY THE DOCTOR, WHETHER OR NOT I AM PRESENT AT THE ACTUAL APPOINTMENT WHEN THE TREATMENT IS RENDERED. I AGREE THAT PARENT(S)/GUARDIANS ARE RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED FOR TREATMENT OF MINOR/CHILD.

DATE: _____ SIGNATURE: _____