SCHWENK FAMILY DENTISTRY
PHILIP H. SCHWENK D.D.S.
1444 EXECUTIVE BLVD. PO Box 827
JASPER, IN 47546 #(812)481-2121

We would like to say thank you for selecting our dental team! So that we may better serve you, please provide or update this information for us. This practice is HIPPA compliant and all information is secured for treatment and insurance purpose only. Your thoroughness is greatly appreciated.

☐ Information In Computer
☐ NP Letter ☐ Thank You Ref. Letter
☐ Scanned

Patient Information

Patient Name:_____ Date:
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____

Social Security #:_____ Birth Date: _____

Phone (Home):_____ (Work):_____ Ext: _____ Cell Phone:_____

Address: _____
Street Apartment # E-MAIL ADDRESS

_____
City State Zip Code

Employer Name:_____ Occupation: _____

Address: _____
Street City State Zip Code

Emergency Contact_____**Relation**_____ **Number**_____

Health Information

Have you ever had any of the following? Please check those that apply:

MEDICAL HISTORY

☐**Abnormal Bleeding**
☐ AIDS/ HIV
☐ Anemia
☐ Arthritis
☐**Artificial Joints**
☐ Asthma
☐**Bacterial Endocarditis**
☐ Blood Disease
☐**Blood Thinners**
☐ Cancer- Type:
☐Chemotherapy
☐Chemical Dependency
☐ Diabetes
☐ Epilepsy/ Seizures
☐**Fosamax**
☐Head Injuries
☐**Heart Attack Year:**____
☐Heart Defect, Congenital
☐Heart Disease
☐Heart Murmur/ MVP
☐**Heart Valve Replacement**
☐**Pacemaker**
☐Hepatitis- Type:
☐**High Blood Pressure**
☐Kidney Disease
☐Low Blood Pressure
☐Mental Health Issues
☐Radiation Treatment
☐Respiratory Problems
☐ Rheumatic Fever
☐Stroke
☐Swollen Neck Glands
☐Thyroid Problems
☐Tuberculosis
☐Tumors/ Growths
☐ Ulcers

WOMEN
☐ Are you pregnant?
Due Date:_____
☐ Are you nursing?
☐ Birth Control

DRUG ALLERGIES
☐Please List:
_____
_____
_____
_____
_____
_____
_____

DENTAL CONCERNS:
Do you have any dental concerns you would like to address today?
_____
_____
_____
Last Dental Visit:_____
_____

MEDICATIONS:
_____
_____
_____
_____
_____
_____
_____
_____
_____

- Have you had **any adverse reactions to dental anesthetics** in the past? _____
- Have you traveled outside US in the past 21 days? If so, any symptoms of illness?_____
- Do you take antibiotics for dental appointments?_____If so, what antibiotic do you take:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No If so, _____

Information for Minors

Mothers Name:_____ Address:_____ Phone:_____

Fathers Name:_____ Address:_____ Phone:_____

We provide radiographs according to the standard of care of dentistry. I give my consent for my child to receive these radiographs.

Signature of Guardian: _____

Responsible Party Information

Name:_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work)_____ Ext._____ Cell Phone or Pager: _____

Address:_____

Street Apartment:_____

_____

City State Zip Code **E-MAIL ADDRESS**

Responsible Party

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary

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 Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Other _____

Insurance Plan Name and Address: _____

Secondary

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 Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If there is any change in my medical status, I will inform the dentist. I understand that this information will be used by my dentist to help determine appropriate and healthful dental treatment. 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 also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me during the period of such care to third party payers and/ or other health practitioners. I grant my permission to you or your assignee to leave confidential information on my home phone or cell phone voicemail if the doctor and/or staff are unable to reach me directly, to facilitate the communication of an appointment or other confidential information. If unable to reach me or leave results on my voicemail, I also authorize Philip H Schwenk DDS, PC to leave confidential information with my spouse/partner directly or on my spouse/partner's home phone or cell phone voicemail.

I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL TREATMENT PERFORMED BY THE DOCTORS AND DENTAL STAFF. I will be responsible for all fees for service rendered. Fees of $25.00 will be charged per returned check. Insurance coverage is a contractual arrangement between myself and the insurance company only. A collection fee in the amount of $45.00 will be added to each account balance that is past due and is turned over to a collection agency or law firm for collection. By signing below, I agree to be financially responsible for all costs of collection, including reasonable attorney fees and court costs.

Printed Name_____ Date: _____ Relationship to Patient: _____

Signature of Patient or Guardian_____