WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

E-mail Address: _____

Name: _____

I prefer to be called:_____ ❑M ❑F ❑Non-binary

Birthdate: __/__/__ Age: ____ SS #: _____

Home Address:_____

_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm #: (____)_____ Cell #:_____

Wk #: (____)_____ Ext: ___ DL #:_____

Employer: _____

Employer's Address: _____

How long there?_____ Occupation: _____

Where & when are the best times to reach you?_____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Visit Date:_____

2 Spouse Information

His / Her Name:_____

Employer: _____

Wk #: (____)_____ Ext: ___ SS #: _____

Birthdate: __/__/__ DL #: _____

Person Responsible for Account:_____

Wk #: (____)_____ Ext: ___ Hm #: (____)_____

Billing Address:_____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address:_____

Insurance Co. Phone #:(____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #:_____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #):_____

Insured's Name: _____ Relation:_____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

4 Medical History

Do you have a personal physician? ❑ **Yes** ❑ **No**

Physician's Name:_____

Phone #: (____)_____ **Last Visit Date:** _____

Are you currently under the care of a physician? ❑ Yes ❑ No

Please Explain: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

CONTINUED ON BACK

5 Medical History
continued

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Do you smoke or use tobacco in any form? ❑ Yes ❑ No

Are you taking any prescription/over-the-counter or herbal supplement drugs? ❑ Yes ❑ No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? ❑ Yes ❑ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❑ Yes ❑ No

For Women:

Are you using a prescribed method of birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol / Drug Abuse	Y	N	Herpes / Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV$^+$ / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Autism	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer / Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Covid-19	Y	N	Psychiatric Treatment
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic /Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Heart Surgery	Y	N	Venereal Disease
Y	N	Hemophilia			

Please list any medical condition(s) that you have ever had:

_____

[redacted] ❑ Yes ❑ No

[redacted] _____ [redacted] _____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry / Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other

Please list any other drugs/materials that you are allergic to:

_____

_____

6 Dental History

Why have you come to the dentist today? _____

_____

_____

Has your doctor told you that you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

I

understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature **Date**

Payment is due in full at time of treatment unless prior arrangements have been approved.

!

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____
2. Date: _____ Comments: _____ Signature: _____
3. Date: _____ Comments: _____ Signature: _____

TRI-HILL FAMILY DENTISTRY

DR. DOUGLAS SCHMITT
& ASSOCIATES

1601 South Queen Street
York, Pennsylvania 17403
(717) 854-9821

FINANCIAL POLICY

In our office, you have a variety of financial options from which to choose.

The office accepts the following forms of payment:

- Cash
- Personal checks
- Visa / Master Card
- Care Credit

Payment in full is due at the time of service unless other arrangements have been made in advance.

The following payment options are available to you:

1. A 5% courtesy on statements of $500 or more that is paid in full by cash or check prior to or at the time of the first treatment appointment.

2. A 2% courtesy on statements of $500 or more that is paid in full by credit card prior to or at the time of the first appointment.

3. In some cases, it may be possible to pay for treatment with 50% due on the day of initial treatment and the balance paid in one or two subsequent payments.

4. **Insurance payments are accepted and we will do everything possible to help maximize your benefits. We use composite material (tooth colored) on posterior teeth. Patients are responsible for the difference between the actual insurance payment and the actual fee.**

5. Costs listed in treatment plans are based on the most accurate determinations the doctor can make at this time. Additional cost may arise if other problems are identified and require further treatment. You are responsible for co-payments required by your insurance and all costs not covered by your insurance plan.

6. **Responsible party also agrees to pay for treatment rendered which is considered as a non-covered service by their insurance company.**

Signature: _____ Date: _____

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of TRI-HILL FAMILY DENTISTRY and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
   A. Preventive hygiene treatment, (prophylaxis) and the application of topical fluoride.
   B. Application of plastic "sealants" to the grooves of the teeth.
   C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
   D. Replacement of missing teeth with dental prostheses, (bridges, partial dentures, full dentures).
   E. Removal (extraction) of one or more teeth.
   F. Treatment of diseased or injured oral tissues (hard and/or soft).
   G. Use of sedative drugs to control apprehension and/or disruptive behavior.
   H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
   I. Use of general anesthesia to accomplish the necessary treatment.
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary are desirable to oral health and well being, in the professional judgement of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
7. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ Time: _____ AM / PM File No: _____

Patient's Name: _____

Name of Parent or Guardian: _____

Relationship to Patient: _____

_____

Signature: Patient or Parent or Guardian Witness

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by: _____ Date: ___/___/___