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 patent, 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: _____