EL CAMINO DENTAL ARTS

Erich S. Schmidt, D.D.S., Inc.
and Associates
1938 Via Centre Suite A • Vista, CA 92081
(760) 433-9255

PATIENT INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

NAME _____ LAST _____ FIRST _____ MIDDLE _____ MARITAL STATUS _____ PREFERRED NAME OR TITLE _____

HOME ADDRESS_____CITY_____ STATE _____ZIP_____

HOME PHONE_____CELL_____WORK_____

PREFERRED METHOD OF CONTACT: EMAIL ☐ TEXT ☐ PHONE ☐ EMAIL_____

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) STREET_____CITY _____STATE _____ ZIP_____

SOCIAL SECURITY NO. _____BIRTH DATE _____DRIVER'S LICENSE NO._____

EMPLOYER_____OCCUPATION_____YEARS EMPLOYED_____

EMPLOYER'S ADDRESS _____CITY_____STATE_____ZIP_____

SPOUSE'S NAME _____SPOUSE'S BIRTH DATE_____ SOCIAL SECURITY NO._____

SPOUSE'S EMPLOYER _____OCCUPATION_____WORK PHONE_____

EMPLOYER'S ADDRESS_____CITY _____STATE _____ ZIP_____

INSURANCE INFORMATION

INSURED'S NAME_____GROUP/POLICY NO._____UNION LOCAL NO._____

EMPLOYER_____

NAME ADDRESS CITY STATE ZIP

INSURANCE CO. _____

NAME ADDRESS CITY STATE ZIP

DO YOU HAVE DUAL (SECONDARY) COVERAGE? ☐YES ☐No; if yes, please complete the following

INSURED'S NAME_____GROUP/POLICY NO._____UNION LOCAL NO._____

EMPLOYER_____

NAME ADDRESS CITY STATE ZIP

INSURANCE CO. _____

NAME ADDRESS CITY STATE ZIP

I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MYSELF OR MY DEPENDENTS IS MINE. IN THE EVENT OF DEFAULT IN PAYMENT, PERSON RESPONSIBLE FOR PAYMENT AGREES TO PAY ANY AND ALL COLLECTION COSTS OF SUIT, INCLUDING ATTORNEYS FEES. I ALSO UNDERSTAND ANY APPOINTMENT NOT CANCELED WITHIN 48 HOURS MAY BE SUBJECT TO A $65 BROKEN APPOINTMENT FEE.
I HEREBY AUTHORIZE PAYMENT OF MY GROUP INSURANCE BENEFITS PAYABLE TO THE DENTIST LISTED ABOVE.
I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATIVE TO THIS CLAIM.

X _____ DATE _____

EMERGENCY INFORMATION

Please list (2) people you would like us to contact in case of emergency.

Family member not living with you #1_____ Phone (___) _____

#2_____ Phone (___) _____

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INSURANCE/ FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. IF YOU HAVE DENTAL INSURANCE, WE ARE HAPPY TO HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS. IN ORDER TO ACHIEVE THESE GOALS, WE NEED YOUR ASSISTANCE AND UNDERSTANDING OF OUR PAYMENT POLICY.

- I understand there are many different insurance carriers and plans that my employer (or spouse's employer) may have chosen to contract with. I understand that my dental office cannot know or be held responsible for all exclusions & restrictions to my plan. If I have questions or concerns regarding my insurance coverage: I may opt to request a preauthorization from my insurance carrier, for diagnosed procedure(s).
- I understand that my dentist may find a procedure dentally necessary, which may not be covered by my insurance policy.
- I understand that my insurance carrier may have negotiated with my employer, a fee schedule different from dental office fee schedule; "Usual & Customary" can vary greatly.
- I understand that my insurance carrier may have been in network with Dr. Schmidt's previous office (or my previous dentist office) but may not be in network with this office.

I have personally read my dental insurance policy, I understand any estimation given by my dental office is approximate, and responsibility for balance of dental services is mine.

Patient's Name (Please Print)_____

Patient or Guardian's Signarure _____ Dated _____

Please note that, unless canceled at least 48 hours in advance, you may be charged a missed appointment fee, please call our office as soon as possible if you need to reschedule.

FOR YOUR CONVENIENCE WE ACCEPT VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, & CARE CREDIT (a line of credit O.A.C.)

Please check one of the boxes below:

☐ I agree that deductibles &/or estimated co-pays will be collected on the Date of Service, Upon receipt of all insurance payments towards my account, I may be billed for any remaining residual balance.

☐ I choose to pay full for all my dental services, rendered on the Date(s) of Service, As a courtesy, my dental office will bill my insurance carrier and sign over insurance benefits to be reimbursed directly to me.

☐ I authorize Erich S. Schmidt D.D.S., Inc to keep my signature on file for the following credit card, to pay for dental services not covered by my insurance carrier, up to $_____ .

Card Type _____ Expiration Date _____

Card Holder Name_____ Zip Code _____

Card Number_____ CVC Code_____

Signature_____ Date _____

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE, do not hesitate to ask us. We are here to help you.

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CONSENT TO TREAT

I. As a rule, excellent results can be achieved with informed and cooperative patients. While recognizing the benefits of good dental health, you should also be aware that dentistry and anesthesia, like any treatment to the body, have inherent risks and limitations. These risks are rarely great enough to rule out treatment, but they should be considered when deciding whether to have any treatment performed. It is impossible to list every possible risk. This should be considered an incomplete list, and you should ask if you have any questions.

DISCOMFORT AND SWELLING- This may necessitate several days of home recuperation.

INJURY- Surgery may result in damage to adjacent teeth and fillings or other dental work.

INFECTION - This may require additional treatment, and in rare cases, hospitalization and further surgery.

BRUISING- Stretching of the corners of the mouth may occur, with resulting cracking or black and blue areas elsewhere.

OPENING- You may experience restricted mouth opening for several days or weeks, or longer.

NUMBNESS- There may be a loss of function of sensory nerve in the area of surgery resulting in tingling or numbness of the tongue on the operated side, accompanied by a possible alteration of taste perception and speech. This does not happen often and its occurrence is usually unpredictable. If numbness should occur, the symptoms may persist for weeks or months while the nerve returns to normal function. In rare instances, such numbness can be permanent.

TMJ PAINS- Some people are very sensitive to even a slight discrepancy in their bite. These patients may suffer from noise, pain or dysfunction in the joint of the lower jaw. (Near the ear). This may occur during or after treatment.

II. ANESTHESIA- When any anesthetic is injected into the body, there may be soreness, inflammation and bruising in the area of injection. Unfavorable or allergic reactions may also occur. Specifically, the mixing of cocaine with certain local anesthetics has resulted in sudden death.

I have been informed about the risk of anesthesia, and I consent to administration of anesthesia in order to accomplish the proposed treatment.

III. PRECAUTIONS AFTER TREATMENT- Medications, drugs and anesthetics may cause drowsiness and reduce awareness and coordination. The effect can be increased by the use of alcohol or other drugs, combining birth control pills with certain antibiotics have eliminated the effect of the birth control pills.

IV. ADDITIONAL TREATMENT- Unforeseen circumstances may cause the doctor to recommend a form of treatment not previously discussed. If this occurs, the doctor will carefully explain the reasons for the change in the treatment plan and any extra fee before proceeding. If any unforeseen condition should arise during the operation, calling for additional or different procedures, I authorize the doctor to do whatever is advisable in his best judgment.

V. SUCCESS OF TREATMENT- This office intends to do everything possible to provide the best result. However, complete success in every case cannot be guaranteed. Due to individual patient differences, there exists a possibility of failure, relapse, or worsening of the patient condition despite the best of care. Successful treatment will take cooperation from everyone-the doctor, the staff, your family, and most of all, you the patient. Our office thanks you in advance for cooperate in this matter.

The doctor has explained the nature of the specific treatment plan to me, including the risk listed above, the alternatives, and the potential consequences for not having the treatment. I have read and understand the above, including the risk and limitations of anesthesia, the possibility of additional treatment, and the possibility that treatment may not be 100% successful. I consent to treatment on these terms.

Patient's Name (Please Print) _____

Dated: _____ Signed: _____

Dated: _____ Doctor: _____

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MEDICAL INFORMATION

Your Pharmacy: Name:_____ Street:_____ Phone:_____

1. General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of your last physical examination: _____

2. Name and phone # of your physician?_____ Telephone No. _____

3. Are you now under the care of a physician? ☐ Yes ☐ No

for what condition _____

4. Are you allergic to any medications? ☐ Yes ☐ No

Please list _____ _____

_____

5 Please list any drugs or medications you are currently taking:

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____

6. Do you take Recreational Drugs (marijuana, cocaine, etc.)? ☐ Yes ☐ No

7. Do you have any disease, problem, or condition that we should know about? ☐ Yes ☐ No

8. Have you ever had antibiotic or other premedication before dental treatment? ☐ Yes ☐ No

9. Do you have any type of prosthetic replacements such as heart valves, hip or knee joints, etc.? ☐ Yes ☐ No List:_____

10. Do you smoke or use tobacco? ☐ Yes ☐ No

11. WOMEN: Are you pregnant? ☐ Yes ☐ No

12. When are you due? _____

13. Do you take birth control pills? ☐ Yes ☐ No

14. Do you, or have you had any of the following?

Rheumatic fever	☐ Yes ☐ No	Major Operation	☐ Yes ☐ No
Heart Operation	☐ Yes ☐ No	Lung/respiratory disease	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Sinus trouble	☐ Yes ☐ No
Heart Murmur or Aliments	☐ Yes ☐ No	Asthma or Allergies	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Fainting Spells	☐ Yes ☐ No
Diabetes, Anemia	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No	Seizures or Epilepsy	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ aNo	Radiation Treatment	☐ Yes ☐ No
Excessive Bleeding	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	AIDS or Test Positive	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Blood Transfusions	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Frequent Headaches	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	Rubber Allergies	☐ Yes ☐ No
Stomach Ulcers	☐ Yes ☐ No	Other: _____	

"To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health, or if my medications change, I will, without fail, inform the doctor immediately."

Signature_____

Dentist Signature_____

DENTAL INFORMATION

1. Are you having dental discomfort today? ☐ Yes ☐ No

2. What treatment would you like today? _____

3. Are you missing any teeth other than wisdom teeth? ☐ Yes ☐ No

4. Have you ever had braces/orthodontics? ☐ Yes ☐ No

5. Do your gums bleed when you brush or floss? ☐ Yes ☐ No

6. Are you concerned about gum disease? ☐ Yes ☐ No

7. Do you have any concerns about the appearance of your teeth? ☐ Yes ☐ No

8. Jaw ever locked open/closed? ☐ Yes ☐ No

9. Jaw or facial pain? ☐ Yes ☐ No

10. Does any type of dental treatment make you nervous? ☐ Yes ☐ No

11. Do you clench or grind your teeth? ☐ Yes ☐ No

12. Do you wear a nightguard or splint? ☐ Yes ☐ No

13. How do you feel about the overall condition of your teeth and mouth?

☐ Excellent ☐Good ☐Fair ☐Poor

14. Name of your previous dentist:_____

City_____ State_____

15. Reasons for changing: _____

_____

_____

16. How long since your last visit and what type of treatment was done?

_____

_____

17. Have you ever had a problem with?

Local Anesthetic? ☐ Yes ☐ No

Previous dental treatment? ☐ Yes ☐ No

Nitrous Oxide sedation? ☐ Yes ☐ No

Cleaning or periodontal therapy? ☐ Yes ☐ No

18. When was your last cleaning or periodontal therapy?_____

19. Do you desire to become a regular continuing care patient in our practice? ☐ Yes ☐ No

20. Do you desire to have your mouth properly restored and disease and pain free? ☐ Yes ☐ No

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Do you have any additional concerns or comments?

_____

_____