

# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## Patient Information

Date \_\_\_\_\_

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Cell Phone \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Email \_\_\_\_\_

## Primary Insurance

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber's # \_\_\_\_\_

Name(s) of other dependents under this plan \_\_\_\_\_

## Additional Insurance

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_ Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber's # \_\_\_\_\_

Name(s) of other dependents under this plan \_\_\_\_\_

Please complete both sides

## Dental History

What would you like us to do today? \_\_\_\_\_

Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Email \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last X-rays \_\_\_\_\_

Check Y for yes or N for no if you have or have not had the following:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath                    | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets       | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold     | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings |
| <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums               | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment         | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth      |

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

## Medical History

Physician's name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Email \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  Y  N If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N If yes, give approximate date(s) \_\_\_\_\_

Have you ever taken Fen-Phen/Redux?  Y  N

Women: Are you pregnant?  Y  N Nursing?  Y  N Taking birth control pills?  Y  N

Check Y for yes or N for no if you have or have not had the following:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive       | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent                | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure           | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis             | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood                   | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain                      | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                         | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism   | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                         | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease                 | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting                         | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies            | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints       | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies                   | (latex, wool, metal, chemicals)   | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                  | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                         | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse         | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone)  | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches                        | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems              | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems           | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur                     | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery       | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease           | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems                   | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care              | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                  | Describe _____   | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss     | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency     | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/<br>Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment           | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy            | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes                           | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease           | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems    | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                        | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic fever               |  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments    |  | <input type="checkbox"/> Y <input type="checkbox"/> N Scarlet fever                 |  |

List medications you are currently taking, if any:

List drug allergies, if any:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Reviewed by \_\_\_\_\_

## Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Timothy A. Schaible, D.M.D & Associates  
340 Mid Rivers Mall Drive, Ste. E  
Saint Peters, MO 63376  
(636) 279-1633

Office Policy Concerning:

Appointments

A minimum charge of \$50.00 will be made for failed or cancelled appointments without prior notification of 24 hours. This charge is a "non-covered" benefit by insurance companies. As a courtesy, we make an effort to remind you of your appointments whenever possible; however, it is your responsibility to cancel or reschedule at least 24 hours prior to your appointment. Once an appointment is made, please remember this time has been reserved for you. If you are more than 10 minutes late for your appointment, your appointment may need to be rescheduled for another day.

Payments

Payments of dental services are due in full the day of your appointment unless other arrangements are made in advance. For your convenience, we accept cash, checks, debit cards, and credit cards (MasterCard, Visa, and Discover). All patients are expected to pay at each dental visit. Patients with dental insurance are asked to pay their estimated co-pay and deductible the day of your appointment. As a courtesy to our patients, we will fill out and file your claim for you. We will not become involved in disputes between you and your insurance company regarding covered charges, deductibles, co-payments, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. If benefits are denied or not paid within two months after filing, patients will be responsible for the balance of their account. No further appointments will be scheduled until patient's co-pays are paid in full. Patients turned over to collection will not be allowed to return to our office for future dental care.

Your signature below indicates that you understand and agree to our office policies.

\_\_\_\_\_  
Patients or Guardian Signature

\_\_\_\_\_  
Date

Insurance patients read and sign below:

Benefit Assignment Authorization

I authorize my insurer to pay Dr. Timothy A. Schaible any dental benefits due me under my dental insurance for services rendered by Dr. Timothy A. Schaible to my dependents or me.

\_\_\_\_\_  
Patient's or Authorized Signature & Date

TIMOTHY A. SCHAIBLE, D.M.D.  
340 MID RIVERS MALL DRIVE, SUITE E  
SAINT PETERS, MO 63376

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\* You May Refuse to Sign This Acknowledgement\*

I, \_\_\_\_\_, have received a copy of this  
office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but  
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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