Date:___________________

Dr. Justin Schlaikjer, D.D.S., M.S.

Patient's Name ____
Last First Middle

Mailing Address ____
Address City State Zip

Patient Date of Birth ____________________Patient S/S#_____________________________ Female/Male Married/Single/Child/Other

EMAIL____

Home Ph. _______________________________ Work Ph. ___________________________ Cell Ph.___________________________

Employer ____ Occupation____

If patient is a minor, Responsible party information: Name: ____
Last First Middle

Spouse's Name ____
Last First Middle

Spouse's Employer ____Spouse's Occupation ____________________________

Is an immediate family member a patient here?____________ Name____

Whom may we thank for referring you to our office? ____

Responsible Party Information

Self _______ Other ____
Yes/No Last First Middle
If "other" please complete:
Date of Birth ____________________ S/S#_____________________________ Relationship to Patient __________________________

Address ____
Street City State Zip

How long at this address _____________ Home Ph. ____________________________ Work Ph. ____________________________

Dental Insurance Information

Insured's Name __________________________________ S/S#___________________________ Date of Birth_____________________

Insured's Employer ____
Zip

Insurance Company __________________________ Group No. _______________________ ID No. _____________________________

Insurance Co. Address ____

Do you have any dual dental coverage? ☐Yes ☐No

Insured's Name __________________________________ S/S#___________________________ Date of Birth_____________________

Insured's Employer ____
Zip

Insurance Company __________________________ Group No. _______________________ ID No. _____________________________

Insurance Co. Address ____

Emergency Information

Name of nearest relative not living with you ____

Address ____ Phone number_______________________

Reason for today's visit ____

1. Are you having pain or discomfort at this time?.. Yes No
2. Have you been a patient in the hospital during the past two years?.. Yes No
3. Have you been under the care of a medical doctor during the past two years?.. Yes No

Physician's Name ____

Address _______________________________________ ________ Phone No. _____________________________

4. Have you taken any medication or drugs during the past two years?.. Yes No
5. Are you now taking any medication, drugs, or pills?.. Yes No

If yes, please list: ____

____

6. Are you currently taking aspirin daily? Yes No What dose?_______________________

7. Do you take a blood thinner? Yes No Name of Med____ Dose__________________

8. Do you require a pre-medication (Antibiotic) for dental visits? Yes No Medication: _______________________ Dose:____________

9. Are you aware of being allergic to or have you ever reacted adversely to any medication or substances?.......................... Yes No

If yes, please list: ____

10. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Murmur………………….	Yes	No	Venereal Disease……………………..…	Yes	No	Diabetes…………………..	Yes	No
Heart Pacemaker………….……	Yes	No	Hepatitis A (infectious)…………….…	Yes	No	Thyroid Problems……….	Yes	No
Mitral Valve Prolaspe…………	Yes	No	Hepatitis B (serum)…………………..	Yes	No	Tuberculosis…………….	Yes	No
High Blood Pressure…………..	Yes	No	Hepatitis C……….…………….……….	Yes	No	Asthma………………….	Yes	No
Heart Surgery………………….	Yes	No	A.I.D.S….…………………………..….	Yes	No	Artificial Joints…………	Yes	No
Rheumatic Fever………………	Yes	No	H.I.V. Positive……………..………..	Yes	No	Psychiatric Treatment….	Yes	No
Epilepsy or Seizures…………..	Yes	No	Bleeding Problems / Hemophilia…..	Yes	No	Cortisone Medicine………	Yes	No
Fainting or Dizzy Spells………	Yes	No	Radiation Therapy……..……………	Yes	No	Cancer…………………….	Yes	No
Latex allergy………………….	Yes	No	Dementia/ Alzheimers……..…………	Yes	No	Cancer type: _______________________		

11. Do you Smoke? Yes No If yes: # of packs per day ___________ ; # of Cigarettes per day_______
12. Do you use Smokeless Tobacco? Yes No

For Women Only:

Are you pregnant? ☐ Yes, what month? __________ ☐ No
Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature____ Date____

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (name of Patient) ____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

ANY PORTION OF A REMAINING BALANCE AFTER NINETY (90) DAYS WILL BE SENT TO A COLLECTION AGENCY.

Patient____Date_________________

Parent or Responsible Party____ Relationship to Patient_____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PURPOSE: This for, is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

I, ____, have received a copy of this Office's Notice of Privacy Practices.

____
Printed Name

____
Signature

____
Date

Authorization to Release Information

PURPOSE: This form is used to obtain authorization to release information regarding yourself, covered under the Privacy Act to people other than yourself.

I, ____, have received a copy of this Office's Notice of Privacy Practices.

________________________________	________________________________
Printed Name	Relationship
________________________________	________________________________
Printed Name	Relationship
________________________________	________________________________
Printed Name	Relationship

For Office Use Only

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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