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 Prolapse	Yes	No	Hepatitis B	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/ Alzheimer's	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, ____, give the persons listed below permission to inquire about my account and/or procedures being preformed within Dr. Schlaikjer's office.

________________________________	________________________________
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)

____

____

____

All Media Release Form

Name: ____

I hereby consent for Dr. Justin Schlaikjer to use, reproduce, exhibit or distribute (in full or part) any photographic, video, film, and/or audio recordings made of me or my likeness; and/or any written extract of such recordings in which I may be included, for any purpose whatsoever, in any medium known or in the future invented, to include future electronic, digital or print promotions which they may produce.

I hereby release, discharge, and agree to hold harmless Dr. Justin Schlaikjer and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio, or photographic production.

Patient signature: ____

Patient print name: ____

Date: _____________________

Address:____

City:_________________ State: ___________ Zip: __________________

If patient is a minor:

Legal guardian: _________________________________

Print name: ____________________________________

Signature ______________________________________

Date:_______________________________

Address: ____

City: ________________ State: ____________ Zip: ______