Patient Information:

Name: ______________________________ Preferred Name ____________ SS# ______________
First Name Last Name Middle Initial

Address: ______________________________ Best Phone: ______________

City: ____________ State: ______ Zip: ____________ Secondary Phone: ______________

E-Mail Address ______________________ Sex ❑M ❑F Birth date: ____________ Age ________

Patient Employer/School ______________________________ Work Phone ______________

Whom may we thank for referring you? ______________ Regular/Previous Dentist ______________

Emergency Contact: ______________ Phone ______________ Relationship ____________

Account Information:

Person Responsible for Account ______________________ Relationship to Patient ____________

Address (if different from patients)

____

Phone Number (if different from patients) ______________________

Primary Dental Insurance:

❑I do not have any dental insurance

Subscriber ______________________ Birth date ____________ SS# ______________

Employer ______________________________ Occupation ______________

Insurance Company ______________________ ID# ______________ Group # __________

Secondary Dental Insurance:

Subscriber ______________________ Birth date ____________ SS# ______________

Employer ______________________________ Occupation ______________

Insurance Company ______________________ ID# ______________ Group # __________

Assignment and Release:

I certify that I, and/or my dependant(s), have insurance coverage with ______________________ and assign directly to Dr.
Name of Insurance Company

Schmidt all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all claim submissions. Dr. Schmidt may use my health care information and may disclose such information to the above-named Insurance Company and their agents to obtain payment for services and determining insurance benefits or the benefits payable for related services.

X____
Signature of Patient, Parent or Guardian (assigning insurance payment to Schmidt Advanced Dentistry)

The information in this packet is true to the best of my knowledge: X______________________________

Signature of Patient, Parent or Guardian Representative DATE

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ______

Name of Physician/and their specialty ______________________

Most recent physical examination ______________ Purpose ______________

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury ______	☐	☐
2. an allergic reaction to ______	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, ______)		
☐ latex		
☐ other ______		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis ______	☐	☐
5. artificial heart valve, repaired heart defect (PFO) ______	☐	☐
6. pacemaker or implantable defibrillator ______	☐	☐
7. orthopedic implant (joint replacement) ______	☐	☐
8. rheumatic or scarlet fever ______	☐	☐
9. high or low blood pressure ______	☐	☐
10. a stroke (taking blood thinners) ______	☐	☐
11. anemia or other blood disorder ______	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) ______	☐	☐
13. emphysema, shortness of breath, sarcoidosis ______	☐	☐
14. tuberculosis, measles, chicken pox ______	☐	☐
15. asthma ______	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease ______	☐	☐
18. liver disease ______	☐	☐
19. jaundice ______	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency ______	☐	☐
21. hormone deficiency ______	☐	☐
22. high cholesterol or taking statin drugs ______	☐	☐
23. diabetes (HbA1c = ______) ______	☐	☐
24. stomach or duodenal ulcer ______	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) ______	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ______	☐	☐

	YES	NO
27. arthritis ______	☐	☐
28. autoimmune disease ______ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma ______	☐	☐
30. contact lenses ______	☐	☐
31. head or neck injuries ______	☐	☐
32. epilepsy, convulsions (seizures) ______	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) ______	☐	☐
34. viral infections and cold sores ______	☐	☐
35. any lumps or swelling in the mouth ______	☐	☐
36. hives, skin rash, hay fever ______	☐	☐
37. STI / STD / HPV ______	☐	☐
38. hepatitis (type ___) ______	☐	☐
39. HIV / AIDS ______	☐	☐
40. tumor, abnormal growth ______	☐	☐
41. radiation therapy ______	☐	☐
42. chemotherapy, immunosuppressive medication ______	☐	☐
43. emotional difficulties ______	☐	☐
44. psychiatric treatment ______	☐	☐
45. antidepressant medication ______	☐	☐
46. alcohol / recreational drug use ______	☐	☐
ARE YOU:		
47. presently being treated for any other illness ______	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ______	☐	☐
49. taking medication for weight management ______	☐	☐
50. taking dietary supplements ______	☐	☐
51. often exhausted or fatigued ______	☐	☐
52. experiencing frequent headaches ______	☐	☐
53. a smoker, smoked previously or use smokeless tobacco __	☐	☐
54. considered a touchy / sensitive person ______	☐	☐
55. often unhappy or depressed ______	☐	☐
56. taking birth control pills ______	☐	☐
57. currently pregnant ______	☐	☐
58. prostate disorders ______	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ______

Doctor's Signature ______________________ Date ______

ASA ______ (1-6) ☐ ◯ ☐

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DENTAL HISTORY

Name ______________________________ Nickname ___________________________ Age __________
Referred by ___________________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist ______________________________ How long have you been a patient? ______________ Months/Years
Date of most recent dental exam _____ /_____ /_____ Date of most recent x-rays ______ /______ / ______
Date of most recent treatment (other than a cleaning) _____ / _____ / _____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] ______ ☐ ☐
2. Have you had an unfavorable dental experience? ______ ☐ ☐
3. Have you ever had complications from past dental treatment? ______ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ______ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ______ ☐ ☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? ______ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ______ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? ______ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? ______ ☐ ☐
11. Have you ever experienced gum recession? ______ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ______ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ______ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ______ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ______ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ______ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ______ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? ______ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ______ ☐ ☐
20. Do you frequently get food caught between any teeth? ______ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ______ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ______ ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ______ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ______ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? ______ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? __ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? ______ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore? ______ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ___ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? ______ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? ______ ☐ ☐
34. Have you ever whitened (bleached) your teeth? ______ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ______ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? ______ ☐ ☐

Patient's Signature ______________________________________ Date ______________
Doctor's Signature ______________________________________ Date ______________

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Authorization for Release of Dental Records

Patient Information

Name: ____

Date of Birth: ____

Address: ____

City: ____

State: ____

Zip: ____

Release My Dental Records From:

Dr. ____

Phone/Fax ____

To:

Kyle K. Schmidt, DDS, MSD
4418 Rucker Ave STE B
Everett, WA 98203
425.374.3226
425.374.8394
Christina@schmidtadvanceddentistry.com
Ellen@schmidtadvanceddentistry.com

Please release a copy of all my dental records, including but not limited to, x-rays and perio charting.

By my signature I authorize release of all dental records.

Patient: ______________________________ Date: ____________________

WRITTEN FINANCIAL POLICY

Thank you for choosing Schmidt Advanced Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

*Cash, Check, Visa or MasterCard
*CareCredit (upon approval)

Please Note:

Kyle K. Schmidt, DDS, MSD, Inc. requires payment prior to the completion of your treatment. Your estimated portion of what your insurance company will not pay, co-pays, and deductible's are due on patient first visit. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and provide you with documentation you need to receive reimbursement for your treatment. **However, please remember that your insurance is a contract between you and your employer and is ultimately your responsibility to know what exactly your insurance offers.**

Please call 48 hours in advance to cancel an appointment and we will reschedule you at a more convenient time.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

____

Patient, Parent or Guardian Signature   Date

____

Patient Name (Please Print)   Date

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, amend our policies and practices but will always inform you of any.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and ant State of Washington. This includes issues relating to your treatment, payment, and out health care operations. Your personal health information will never be otherwise given to anyone- even family members- without your written consent. You of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that our protected health information will never be improperly disclosed or released.

Collecting Protected Health Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operation, and comply with the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligates to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including messages, answering machines, or sometimes postcards. Any breach in the protection of your personal health information, including unauthorized acquisition, access, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Rule. You have a right to and will be provided all information relating to any breach involving your PHI.

Your Rights as our Patient

You have a right to request copies of your healthcare information, and to request a list of instances in which we, our business associates, have disclosed your protected information for uses other than stated above. All requests must be in writing. We may charge you for the copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

Acknowledge of Receipt

I acknowledge that I received a copy of Dr. Kyle K Schmidt's Notice of Privacy Practices.

Patient Name____

Signature_____________________________________ Date______________

I authorize _______________________________ full access to my dental information (ie: spouse, friend, sibling....)