



5545 Colony Drive North, Saginaw, MI 48638 • (989) 799-0675
<http://www.jenniferschaudds.com/>



Patient Information

Date _____ SS/HIC/Patient ID# _____ Patient Name _____
 Address _____ City _____ State _____ ZIP _____
 E-mail _____ Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor Separated Divorced Partnered
 Patient Employer / School _____ Occupation _____
 Employer / School Address _____
 Employer / School Phone (_____) _____ Spouse's Name _____
 Birthdate _____ SS # _____ Spouse's Employer _____
 Whom may we thank for referring you? _____



Phone Numbers

Home (_____) _____ Work (_____) _____ Ext. ____ Cell Phone (_____) _____
 Spouse's Work (_____) _____ Best time to reach you _____
IN CASE OF EMERGENCY CONTACT (Please specify someone who does NOT live in you household.)
 Name _____ Relationship _____
 Home Phone number (_____) _____ Work Phone (_____) _____



Dental Insurance

Who is responsible for this account? _____ Relationship to patient _____
 Insurance Co. _____ Group # _____
 Is patient covered by secondary insurance? Y N Subscriber's Name _____
 Birthdate _____ SS# _____ Relationship to patient _____ Insurance Co. _____
 Group # _____



Dental History

Reason for Today's Visit _____ Date of last dental care _____
 Former Dentist _____ Date of last dental X-rays _____
 Address _____
 Check Yes Or No (✓) if you have had problems with any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growth in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain when brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____	
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction to Local Anesthetic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to hot	<input type="checkbox"/> Yes <input type="checkbox"/> No		



Health History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Bleeding abnormally with extractions or surgery |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Fainting | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Congenital Heart Disease |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Headaches | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Nervous problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis Type ____ | <input type="checkbox"/> Swelling of Feet or Ankles | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tobacco Habit | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tumor or growth on head or neck |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Weight Loss, unexplained |
| <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Any Osteoporosis Medication |
| <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | | |



Medications / Over the Counter / Vitamins

List any medications you are currently taking and the correlating diagnosis.

Pharmacy Name _____ Phone (____) _____

Vitamins: _____



Allergies

Aspirin Barbiturates (sleeping pills) Codeine Iodine Latex Local anesthetic Penicillin Sulfa

Other: _____



ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly
Name of Insurance Company(ies)

to Dr. Schau 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 submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative.

Date

Please print name of Patient, Parent, Guardian or Personal Representative.

Relationship to Patient

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? Yes No

For what conditions? _____

Is the patient taking any new medications? Yes No If so, What? _____

Date

Patient Signature

Has there been any change in the patient's health since the last dental appointment? Yes No

For what conditions? _____

Is the patient taking any new medications? Yes No If so, What? _____

Date

Patient Signature

Has there been any change in the patient's health since the last dental appointment? Yes No

For what conditions? _____

Is the patient taking any new medications? Yes No If so, What? _____

Date

Patient Signature

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For what conditions? _____

Is the patient taking any new medications? Yes No If so, What? _____

Date

Patient Signature

Has there been any change in the patient's health since the last dental appointment? Yes No

For what conditions? _____

Is the patient taking any new medications? Yes No If so, What? _____

Date

Patient Signature

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITY IN THE FUTURE.

Please **print** your name

Please **sign** your name

Legal Representative

Description of Authority

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Sir Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email | |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- | | |
|--|-------|
| It was emergency treatment | _____ |
| I could not communicate with the patient | _____ |
| The patient refused to sign | _____ |
| The patient was unable to sign because | _____ |
| Other (please describe) | _____ |

Signature of Privacy Officer