Jennifer Schau DDS
Gentle Family Dentistry

Dental Registration & History

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

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

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 ad 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 .

Jennifer Schau DDS
Gentle Family Dentistry

5545 Colony Drive North
Saginaw, MI 48638
Phone 989-799-0675 /Fax 989-799-0695

AUTHORIZATION TO RELEASE MEDICAL / DENTAL RECORDS

Patient Name: _____

Previous Name: _____

Date of Birth:_____ ***Social Security:***_____

I request and authorize **Dr. Jennifer Schau D.D.S.** ***to release all healthcare information of the patient named above.***

Being Sent To:_____
Address:_____

Phone:_____

Email:_____

Fax:_____

Patient Signature: _____

Date Signed:_____

OFFICE USE ONLY

Last CLEANING:_____PERIO

RECALL:_____

CURRENT X RAYS: FMX: _____PANO:

_____BW:_____

Send x-rays to kathy@jenniferschaudds.com

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT \ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & 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 the healthcare facility. A copy of this signed, dated document shall be as effective as the original.

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

_____

PRINT PATIENT NAME ***SIGN YOUR NAME*** ***REALATIONSHIP TO MINOR***

_____

LEGAL REPRESENTATIVE-POWER OF ATTORNEY ***DESCRIPTION OF AUTHORITY***

Your comments regarding Acknowledgements or Consents:

_____

_____

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

CHECK ONE: ☐ ***FIRST NAME ONLY*** ☐ ***PROPER SURNAME*** ☐ ***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:

___ CELL PHONE CONFIRMATION
___ HOME PHONE CONFIRMATION
___ WORK PHONE CONFIRMATION
___TEXT MESSAGE TO MY CELL PHONE
___ EMAIL CONFIRMATION
___ **ANY OF THE ABOVE**

I AUTHORIZE THAT INFORMATION ABOUT MY HEALTH MAY BE CONVEYED VIA:

___ CELL PHONE CONFIRMATION
___ HOME PHONE CONFIRMATION
___ WORK PHONE CONFIRMATION
___ TEXT MESSAGE TO MY CELL PHONE
___ EMAIL CONFIRMATION
___ **ANY OF THE ABOVE**

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFO ON BEHALF OF THIS HEATHCARE FACILITY VIA:

___ CELL PHONE CONFIRMATION
___ HOME PHONE CONFIRMATION
___ WORK PHONE CONFIRMATION
___TEXT MESSAGE TO MY CELL PHONE
___EMAIL CONFIRMATION
___**ANY OF THE ABOVE…… NONE**_____

In signing this HIPPA 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 HIPPA Omnibus Rule, provide you this information with your knowledge and consent.