JOHN A. SCHACHERL, D.D.S.
KATHERINE C. SCHACHERL, D.D.S.
DENTAL & MEDICAL HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION TODAY'S DATE:_____ DATE OF BIRTH:____/____/____

PATIENT NAME:_____ SOCIAL SECURITY NO. _____

ADDRESS_____

HOME PHONE_____ CELL_____ WORK_____

EMAIL_____NAME OF SPOUSE_____

BEST TIME/PHONE TO CONTACT YOU_____AM/PM Home Phone Cell Work Phone

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

The following information about your dental and medical health is very important. It allows us to provide you with the safest possible treatment. Incorrect information may be dangerous to your health. Please answer all questions completely and accurately. If you do not understand a question or are unsure of an answer or wish to discuss it with Dr. Schacherl, please inform us of this. The information on this Dental & Medical Health History Questionnaire will be viewed by our office personnel only and is considered confidential information.

Please state any concerns you have about your dental health:_____

_____

_____

Date of your last dental check-up:_____

Please answer "Yes" or "No" to each of the following:

Are your teeth sensitive to:	**Yes**	**No**
Heat	_____	_____
Cold	_____	_____
Sweets	_____	_____
Biting Pressure	_____	_____
Does food wedge easily between your teeth?	_____	_____
Do any teeth feel loose?	_____	_____
Have you noticed gum swelling?	_____	_____
Do your gums bleed when brushing or flossing?	_____	_____
Do you brush your teeth daily?	_____	_____
Do you floss your teeth daily?	_____	_____
Have your gums ever been treated?	_____	_____
Do you experience bad tastes or odors in your mouth?	_____	_____
Have your teeth ever been straightened (braces)?	_____	_____
Have you experienced problems with dental anesthetics?	_____	_____
Do you experience frequent pain:		
In your ears	_____	_____
In your head (including headaches)	_____	_____
In your neck	_____	_____
In your shoulders	_____	_____
Do you have a clicking jaw joint?	_____	_____
Have you ever injured:		
Your head	_____	_____
Your jaw	_____	_____
Do you clench or grind your teeth?	_____	_____
Do you have all of your natural teeth?	_____	_____
If "No," have missing teeth been replaced?	_____	_____
Are you happy with the appearance of your smile?	Yes	No
If "No," what would you change?_____		
_____		
Would you like to have whiter teeth?	Yes	No

MEDICAL HISTORY

Do you have any general health problems? Yes No
If "Yes," please explain:_____

_____

Are you presently being treated by a physician? Yes No
If "Yes," please explain:_____

_____

List any medications you are taking (prescription and non-prescription, over-the-counter, vitamins, supplements, contraceptives, etc.)_____

_____

_____

_____

Please state any known allergies:_____

_____

_____

Are you allergic to latex? Yes No

Have you ever had, or do you presently have, any of the following? PLEASE CHECK ALL THAT APPLY

_____AIDS/HIV	_____Diabetes - Type 1	_____Kidney Disease
_____Sinus Problems	_____Diabetes - Type 2	_____Glaucoma
_____Anemia	_____Epilepsy	_____Hepatitis (Type_____)
_____Liver Disease	_____Stomach Problems	_____Arthritis
_____Excessive Bleeding	_____Mental Health Disorders	_____Stroke
_____Artificial Joints	_____Fainting	_____Nervous Disorders
_____Tuberculosis	_____Asthma	_____Blood Disease
_____Blood Transfusions	_____Depression	_____Cancer
_____Dizziness	_____Heart Disease	_____Jaundice
_____Emphysema	_____Rheumatic Fever	_____Valve Replacement
_____Tumors	_____Ulcers	_____Sexually Transmitted Disease
_____Thyroid Problems	_____Pacemaker	_____High/Low Blood Pressure
_____Shortness of Breath	_____Respiratory Problems	_____Heart Murmur
_____Chest Pain	_____Radiation Therapy to Head or Neck	

Do you smoke or use tobacco products? Yes No
Do you have a history of narcotic abuse? Yes No
Have you ever been told that you require PRE-MEDICATION prior to dental treatment? Yes No
Have you ever taken any of the following medications?
Phen-Fen (phentermine & fenfluramine) Yes No
Pondimin (fenflueamine) Yes No
Redux (dexfenflueamine Yes No
Have you ever been treated for osteoporosis? Yes No
Are you being treated for any other bone disease or cancer? Yes No

Have you taken, or are you taking, any of the following medications?
Aredia (pamidronate) Yes No
Zometa (zolendronic acid) Yes No
Actonel (risendronate) Yes No
Fosamax (alendronate) Yes No

Have you ever been turned down as a blood donor? Yes No

FOR WOMEN ONLY: Are you pregnant? Yes No
Due Date:_____

I understand that the information I provide on this form is essential to my dental needs so that this office can provide proper dental treatment. I agree that if any change occurs in my health, I will report it to this office as soon as possible. I have read and understood each question contained in this form, and have answered each question completely and truthfully to the best of my ability.

_____ / _____

Patient Signature Date DDS Signature Date

JOHN A. SCHACHERL, D.D.S.
KATHERINE C. SCHACHERL, D.D.S.
FINANCIAL RESPONSIBILITY AGREEMENT

FOR PATIENTS WITH DENTAL INSURANCE

Primary Insurance – Dental
Name of Insured_____ Is insured a Patient? Yes No

Patient's Relationship to Insured? Self Spouse Child Other

Insured's Date of Birth_____ Insured's ID#_____

Insured's Group#_____ Insured's Employer_____

Insured's Address_____

Insurance Plan Name & Address_____

Secondary Insurance – Dental
Name of Insured_____ Is Insured a Patient? Yes No

Patient's Relationship to Insured? Self Spouse Child Other

Insured's Date of Birth_____ Insured's ID#_____

Insured's Group#_____ Insured's Employer_____

Insured's Address_____

Insurance Plan Name & Address_____

FOR PRIVATE-PAY PATIENTS

Patient's Employer_____

Employer's Address_____

Spouse's Name_____

Spouse's Employer_____

Employer's Address_____

FOR ALL PATIENTS - FINANCIAL RESPONSIBILTY AGREEMENT
I agree to financial responsibility for the charges that I incur at this office. If this form is being completed for any minor child of mine, I agree to financial responsibility for the charges which are incurred on behalf of my minor child. If I am covered by dental insurance, I understand that my dental insurance may pay only a portion of the charges which I have incurred, and I agree to assume financial responsibility for and pay the balance.

_____

Patient Signature Date