Martin D. Scheer, D.D.S.
230 E. 22nd Street • Fremont, NE 68025 • (402) 721-8200

PATIENT HEALTH RECORD

Date _____

Patient Name _____

Address _____ Email: _____

City, State _____ Zip _____

Birth Date _____ Sex: M F Marital Status _____

Occupation/Employer _____ Soc. Security No. _____

Phone _____ Work Phone _____ Cell Phone _____

Spouse or Parent Name _____

Occupation/Employer _____ Soc. Security No. _____

Phone _____ Work Phone _____ Cell Phone _____

Nearest Relative (Not living with you) _____

Address _____

Phone Number _____ Relationship _____

Primary Insurance (Dental) _____

Secondary Insurance (Dental) _____

Name of Physician _____ Phone _____

Referred by _____

DENTAL HEALTH

Reason for visit today: _____

Reason for last dental visit: _____

When was your last dental visit? _____ Do you like your smile? _____

Is there anything you would like to change? _____

YES / NO Do your gums feel tender or swollen?
YES / NO Do your gums bleed while brushing or flossing?
YES / NO Do you avoid brushing any part of your mouth because of pain or bleeding?
YES / NO Do you chew on only one side of your mouth?
YES / NO Do your teeth bother you with (a) Hot (b) Cold (c) Sweet?
YES / NO Do you have pain during or after chewing, talking or opening?
YES / NO Do you grind or clench your jaws during the day or while sleeping?
YES / NO Do your jaws ever feel tired?
YES / NO Are you familiar with the term "Preventative Dentistry"?

MEDICAL HEALTH

YES / NO Are you having pain or discomfort at this time?
YES / NO Do you feel nervous about having dental treatment?
YES / NO Have you ever had a bad experience in the dental office?
YES / NO Have you been under the care of a medical doctor during the past two years?

_____

YES / NO Have you been a patient in the hospital over the past two years?

_____

YES / NO Have you taken any medicine or drugs during the past two years?
Itemize: _____

YES / NO Are you allergic to or made you sick by PENICILLIN, ASPIRIN, CODEINE, SULFA, HOUSEHOLD BLEACH, OR OTHER DRUGS or MEDICATIONS?

Circle any of the following which you have had or have at present:

Trench Mouth	Emphysema	Hepatitis A (infectious)
Heart Failure	Tuberculosis	Hepatitis B (serum)
Heart Disease or Attack	Asthma	Hepatitis C
Angina Pectoris	Hay Fever	Liver Disease
High Blood Pressure	Sinus Trouble	Yellow Jaundice
Heart Murmur	Allergies or Hives	Drug Addiction
Rheumatic Fever	Diabetes	Hemophilia
Scarlet Fever	X-ray of Cobalt Treatment	Cold Sores
Heart Pacemaker	Rheumatism	Epilepsy/Seizures
Heart Surgery	Cortisone Medicine	Fainting/Dizzy
Artificial Joint	Glaucoma	Nervousness
Anemia	Anorexia Nervosa	Psychiatric Treatment
Stroke	Headaches	Sickle Cell Disease
Kidney Trouble	HIV/AIDS	Bruise Easily
Bulimia	Venereal Disease	Ulcers
Thyroid Disease	Genital Herpes	Congenital Heart Lesions

YES / NO When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or you are very tired?
YES / NO Do your ankles swell during the day?
YES / NO Do you ever wake from sleep short of breath?
YES / NO Do you have any disease, condition, or problem not listed?

_____

WOMEN: YES / NO Are you pregnant now?
YES / NO Are you taking birth control?
YES / NO Do you anticipate on becoming pregnant?

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health history or medications, I will inform the doctor at my next appointment without fail.

_____

Signature of patient or parent or guardian if minor Date

SCHEER
Family Dentistry

PATIENT CONSENT

Clinical

1. I authorize Scheer Family Dentistry to perform recommended treatment.
2. I authorize the practice to take radiographs, photos, study models and other diagnostic aids or materials (collectively 'Diagnostic Material') as needed to make a thorough diagnosis. I authorized that such Diagnostic Material may be released to third-party payers and/or other health care practitioners.
3. I authorize the use of anesthetics, sedatives and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment for all services rendered on my behalf and understand that the deductible and co-payments are due at the time of service. Emergency patients must pay for service in full at time of treatment. We accept cash, check, Visa, Master Card, Discover and Care Credit.
5. A $35 missed appointment fee will be charged to my account for all missed or cancelled appointments with less than 24 hour notice.
6. Senior citizen discount, starts at age 65, with no dental insurance:
   10% off by cash or check, paying in full at time of service
   7% off by debit or credit card, paying in full at time of service
7. An 18% APR finance charge will be applied on balances that are 90 days past due.
8. A fee of $30 will be applied to all returned checks.

Insurance

9. I authorize Scheer Family Dentistry to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payors and/or other health care practitioners.
10. I authorize Scheer Family Dentistry to submit claims of services rendered or pre-authorizations to my insurance company on my behalf. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I will notify the dental office if there has been a change in dental insurance.

Notice of Privacy Practices

11. I have received a copy of Scheer Family Dentistry's Notice of Privacy Practices.

I have read this Patient Consent and understand all terms and conditions herein regarding Scheer Family Dentistry.

_____ _____

(Signature) (Date)

SCHEER
Family Dentistry

Name: _____
Last First

Date: _____

Please tell us how you learned about our practice. (Select ALL that apply).

_____ Referral – Patient Name: _____

_____ Referral – Staff Name: _____

_____ Referral – Dentist/Dr Name: _____

_____ Our website

_____ Internet search (e.g. a basic search for "dentist")

_____ Insurance Company Which insurance? _____

_____ Facebook