S C H M I D T

FAMILY & COSMETIC DENTISTRY

4963 MACKINAW RD., SAGINAW, MI 48603
PAUL M. SCHMIDT, D.D.S., P.C.

Patient Registration and Medical History

(Please Print)

Date: _______________

Patient Information:

Patient's Name: ____

(Last Name) (First Name) (Initial) (Preferred Name)

Street Address: ______________________________ City: ______________________ State: ______ Zip: _________

Home Phone: _________________ Cell Phone: ________________ E-Mail Address: ___________________________

Age: _____________ Birth date: _________________________ Soc. Sec. #: ____________________________________

(Please Circle)
Sex: M F Marital Status: Minor Single Married Divorced Widowed Separated

Employed by: ____ Occupation: __________________________________

Employer's Address: ______________________________ City: ___________________ State: _____ Zip: _________

Work Phone: ___________________________________ Ext: ______________________

Spouse or Parent's Name: ______________________________ Spouse or Parent's Birth date: ___________________

Spouse or Parent's Employed by: ____

Spouse or Parent's Soc. Sec. #: _________________________________ Occupation: ___________________________

Employer's Address: ______________________________ City: ___________________ State: _____ Zip: _________

Work Phone: ___________________________________ Ext: ______________________

Person to Contact in Case of Emergency: ______________________________________ Phone: __________________

Whom May We Thank for Referring You: ____

Name of Person Responsible for Account: _________________________________ Relationship to patient: __________________

Insurance Information:

Primary Insurance	***Secondary Insurance***
Insured's Name: __________________________________	Insured's Name: __________________________________
Group #: _________ Insured's I.D. #: _______________	Group #: _________ Insured's I.D. #: _______________
Employer:_______________________________________	Employer:_______________________________________
Insurance Carrier: ________________________________	Insurance Carrier: ________________________________
Insured's Birth date: ______________________________	Insured's Birth date: ______________________________

Name: ____

Healthy History:

Date of last health care exam: ____________ What was this exam for? ______________________________

Have you been hospitalized in the last 5 years? No Yes If yes, reason: ___________________________

Please list all the names and phone number of the physicians who are currently providing you care:

	Name	Phone
1.	____	______________________________
2.	____	______________________________
3.	____	______________________________
4.	____	______________________________

Do you or have you have any of the following: (Please color No or Yes)

Condition	No	Yes
Anemia or Blood Disorder	No	Yes
Arthritis, Rheumatism or other inflammatory disease	No	Yes
Asthma	No	Yes
Abnormal Bleeding from a cut	No	Yes
Cancer or Tumor Where: ________________	No	Yes
Diabetes	No	Yes
Emphysema or other Respiratory/Lung Illness	No	Yes
Epilepsy	No	Yes
Fainting or Dizzy Spells	No	Yes
Glaucoma	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes
Heart Disease, Heart Attach, Heart Surgery	No	Yes
Heart Murmur (mitral valve prolapsed)	No	Yes
Heart Stent? When placed? ________________	No	Yes
Hepatitis? What From? ________________	No	Yes
Joint Replacement? When placed? ______________	No	Yes
Kidney Disease	No	Yes
Liver Disease (including Jaundice)	No	Yes
Sore/Enlarged Lymph Nodes	No	Yes
Psychosis	No	Yes
Previous Biopsies What: ________________	No	Yes
Radiation Treatment When: ________________	No	Yes
Chemotherapy Treatment When: ________________	No	Yes
Rheumatic Fever	No	Yes
Slow-Healing Mouth Sores	No	Yes
Unintentional Weight Loss/Gain	No	Yes
H.I.V. Infections/AIDS or ARC	No	Yes
Venereal Disease	No	Yes
Recurrent Illnesses	No	Yes
Other Conditions What: ________________	No	Yes

Name: ____

Are you taking any of these medications: (Please circle No or Yes)

Medication	No	Yes
Pre-medication before dental treatment	No	Yes
Antacids	No	Yes
Tagamet (Cimetidine)	No	Yes
Prilosec (Omeprazole)	No	Yes
Cardizem (Diltiazem)	No	Yes
Calan	No	Yes
Isoptin (Verapamil)	No	Yes
Dialantin	No	Yes

Medication	No	Yes
Tegretol	No	Yes
Serzone (Nefazodone)	No	Yes
Diflucan (Fluconazole)	No	Yes
Sporonox (Itraconazole)	No	Yes
Biaxin (Clarithromycin)	No	Yes
Barbiturates (any)	No	Yes
St. John Woth	No	Yes
Kava-Kava	No	Yes

Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? If so, when did the treatment begin? ___________________________ When did the treatment end? __________________________

(Please Circle No or Yes)
Have you ever taken any prescription drugs such as Fen-phen for weight loss? No Yes

Do you consume grapefruit juice, grapefruit extract? No Yes

Please list any medications you are currently taking:

Medication	Dosage	Frequency	Reason
1. ________	1. ____	1. ____	1. ________
2. ________	2. ____	2. ____	2. ________
3. ________	3. ____	3. ____	3. ________
4. ________	4. ____	4. ____	4. ________
5. ________	5. ____	5. ____	5. ________
6. ________	6. ____	6. ____	6. ________
7. ________	7. ____	7. ____	7. ________
8. ________	8. ____	8. ____	8. ________

Please list any dietart or herbal supplements you are taking and for what purpose:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Are you allergic or have you had a reaction to any of the following: (Please Circle No or Yes)

Item	No	Yes
Local Anesthetics	No	Yes
Penicillin	No	Yes
Other Antibiotics What: ______________________	No	Yes
Aspirin	No	Yes
Ibuprofen	No	Yes
Tylenol	No	Yes
Codeine	No	Yes
Valium	No	Yes
Other Sedatives What: ______________________	No	Yes
Latex	No	Yes
Metals	No	Yes
Foods What: ______________________	No	Yes
Other please specify: ______________________	No	Yes

Name: ____

Abnormal Blood Pressure? (Please Circle)

Have you ever received a diagnosis of "high blood pressure" No Yes

What is your normal blood pressure? S _________/D __________ Today: S ________/D ________

What is your weight? ___________

What is your sugar intake (circle one) none slight moderate high

Do you drink: (please circle) pop Gatorade energy drinks How much per day? ______________

(Please circle No or Yes)

Do you use tobacco? No Yes

Which type: Smoke Chew

How much per day? ______________________ For how long? _______________________________

Do you want to quit using tobacco? No Yes

Do you consume alcohol? No Yes If yes approximately how many alcoholic beverage per week? _______

Do you use any mood altering drugs other than those previously listed? No Yes

Women Only: (Please circle No or Yes)

Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Read Carefully and Understand what your signature means. Your signature below serves many purposes. It indicates you have reviewed your medical history and updated and corrected it as appropriate. Also, your signature below shall constitute your "Signature on File" with your insurance company (if applicable) for assignment of your insurance benefits to Dr. Paul Schmidt D.D.S. and the release of information to all insurance carriers. And finally, the undersigned agrees, whether or not he/she has dental insurance, he/she is responsible for payment of all services rendered, and that co-pays will be made at the time of service unless previous financial arrangements have been made with the Financial Coordinator. All information is protected by Doctor-Patient confidentiality. You will be held responsible if statements or representations are untrue. Please update and sign once per visit.

Signature ____ Date: ___________________________