

WELCOME

You are joining a very special group of people...our patients. We are a complete dental care team specially trained to offer a wide range of dental services. Your health and comfort is our primary concern with our ultimate goal being prevention and control of dental disease.

Your First Visit

We require a completed health questionnaire when you arrive. For your protection we must know the condition of your health. During the initial visit the doctor will perform a complete oral examination. This examination will include the necessary X-rays and other procedures required to make a thorough and accurate diagnosis.

Your Future Appointments

We believe every patient should understand the status of their dental condition and what is required, if necessary, to restore their mouth to optimum health. After our examination, we will discuss a practical treatment plan with you. This plan will tell us where we are going, approximately how long it will take to get there, and what the investment will be.

Emergencies

We are available for emergency care. We will take immediate steps to relieve any discomfort you or a member of your family may be experiencing. If an emergency situation should arise, please call us as early in the morning as possible or leave message on our after hours voice messaging line. We will accommodate you at the absolute earliest possible time.

Insurance and Payment

For your convenience we accept Visa, MasterCard, American Express and Discover. We offer alternative financial arrangements with approved credit. Your dental insurance is a contract between you and your company. We will be happy to help you claim all insurance benefits to which you are entitled; however, ultimately you are responsible for your account.

We are delighted you have joined us and will work very hard to serve your needs.

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Name of person responsible for payment: _____

(if not your insurance company)

MEDICAL/DENTAL HISTORY

Do you have a personal physician? yes no

Physician's name: _____ Phone # (____)____-_____

Date of last visit to see a doctor? _____ Reason: _____

Have you been hospitalized in the past 2 years? yes no Reason: _____

Are you currently under the care of a physician? yes no Reason: _____

Previous dentist's name: _____ Phone # (____)____-_____

Reason left previous dentist: _____

What is your most immediate dental concern? _____

Do you or have you ever had any of the following diseases or medical problems

(check yes or no for EACH)

- | | |
|---------------------------------------|--------------------------------|
| Y__N__ ABNORMAL BLEEDING | Y__N__ HEPATITIS |
| Y__N__ ALCOHOL/DRUG ABUSE | Y__N__ HERPES/FEVER BLISTERS |
| Y__N__ ANEMIA | Y__N__ HIGH BLOOD PRESSURE |
| Y__N__ ARTHRITIS | Y__N__ HIV+/AIDS |
| Y__N__ ARTIFICIAL BONES/JOINTS/VALVES | Y__N__ KIDNEY/LIVER DISEASE |
| Y__N__ ASTHMA/HAY FEVER | Y__N__ LUPUS |
| Y__N__ BLOOD DISEASE/TRANSFUSIONS | Y__N__ MITRAL VALVE PROLAPSE |
| Y__N__ CANCER/CHEMOTHERAPY | Y__N__ OSTEOPOROSIS MEDICATION |
| Y__N__ COLITIS | Y__N__ PACEMAKER |
| Y__N__ DIABETES | Y__N__ PSYCHIATRIC CARE |
| Y__N__ EMPHYSEMA | Y__N__ RADIATION TREATMENT |
| Y__N__ EPILEPSY | Y__N__ RESPIRATORY DISEASE |
| Y__N__ FAINTING SPELLS | Y__N__ RHEUMATIC/SCARLET FEVER |
| Y__N__ FREQUENT HEADACHES | Y__N__ SICKLE CELL DISEASE |
| Y__N__ HEART DISEASE | Y__N__ SMOKE? |
| Y__N__ HEART MURMUR | Y__N__ STROKE |
| Y__N__ HEART SURGERY | Y__N__ TUBERCULOSIS (TB) |

Have you had an unfavorable reaction to previous treatment? yes no Explain: _____

Are you taking any medication? yes no Explain: _____

Are you pregnant? yes no

Allergies? (Y__N__ Penicillin); (Y__N__ other antibiotics); (Y__N__ local anesthetics); (Y__N__ Codeine)

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status

Signature _____ Date: ____/____/____

(patient/parent)

