David J Schrad D.D.S., PC
1415 Harney Street Suite 100
Omaha, NE 68102
(402)341-7576

Patient Information:

Name: ____ Date of Birth:_______________________
Address:_____________________________City:__________________State:__________Zip:__________
Home Phone:________________ Work Phone:__________________ Cell Phone:___________________
E-Mail Address:____
Marital Status: S / M / D / W   Sex: M / F   SSN:____
Place of Employment:_________________________________ Address:___________________________
Emergency Contact Name:______________________________ Phone #:__________________________

Parent/Guardian Information if Patient is a Minor:

Name:____ Relationship to Patient:_______________
Address: ________________________________City:________________State:_________Zip:__________
Phone Number: ____________________________________ □ Home   □ Work   □ Mobile
E-Mail Address: ____
How did you hear about our office: □ internet □ mailer □ friend □ family □ co-worker
□other:________________________________
-We like to ensure our patients are rewarded for their referrals, is there someone specific we can thank for referring you to our office? ____

Insurance Information: Are you the subscriber on your dental insurance?   □ Yes   □ No
Insurance Company:____ Group #:____________________

If you are not the Subscriber:

Subscriber's Name:___________________________________ Relationship:______________________
Address:________________________________ City:__________________ State:_______ Zip:__________
Date of Birth:_________________ SSN:_____________________ Employer:_______________________

Medical History:

Primary Physician: _____________________________________ Date of Last Physical Exam:___________
Are you currently / recently been under a physician's care? □ Yes □ No Reason:__________________
Have you ever been a patient in a hospital or had any serious illness? □ Yes □ No
Explain:____

Check any of the following that you have had or suspected:

__Arthritis	__Hepatitis	__Jaundice	__Prolonged Bleeding
__Rheumatic Fever	__Liver Disease	__Fainting Tendency	__Heart Trouble
__Cancer/Tumor	__Epilepsy	__Heart Murmur	__Tuberculosis
__Thyroid Disease	__High Blood Pressure	__Low Blood Pressure	__Diabetes
__Glaucoma	__Chest Pain	__Kidney/Bladder Trouble	__Radiation Treatment
__Stroke	__Anemia	__Mental Disorders	__Shortness of Breath
__Lung Disease	__HIV or AIDS	__Asthma	__Hay Fever
__Venereal Disease	__Blood Transfusion	__Sinus Trouble	__Blood Disease
__Prosthetic Joint Replacement			

(See Reverse)

Check any of the following that you are taking or have taken:

__Cortisone Drugs __Anticoagulants __Tranquilizers __Steroids __Sedatives
__Blood Thinners __Bisphosphonates (Fosamax) __Fen-Phen

Are you allergic to or suffer ill effects from any of the following?
__Penicillin __Codeine __Dental Anesthesia __Aspirin __Household Bleach
__Latex __Sulfa __Other:____

Women Only: Are you pregnant? □ Yes □ No If yes, months?______ Are you breast feeding? □ Yes □ No

Dental History:
Date of last Dental Visit:___________ Where?________________________ X-Rays Sent? □ Yes □ No
For what reason do you wish to see the doctor today? ____
Do you have other dental complaints at this time? Explain:______________________________________
How do you feel about the appearance of your teeth?____
Would you like your smile to be?: □Whiter □Straighter □A different shape
□Yes □No Are you interested in Botox for cosmetic or pain relief reasons?
□Yes □No Do your gums bleed when brushing or flossing?
□Yes □No Have you ever had trouble with prolonged bleeding after dental surgery?
□Yes □No Do you frequently get headaches?
□Yes □No Do you habitually clench your teeth?
□Yes □No Is your jaw sore or tired when you wake?
□Yes □No Does your jaw pop or click when opening or closing?
□Yes □No Have you ever had any instruction on the correct brushing of your teeth?
□Yes □No Do you feel nervous about having dental treatment?
□Yes □No Have you ever had a bad experience in a dental office? Explain:____________________

Method of Payment: **Payment is due on the day services are rendered.**

- □ Cash or Check
- □ Visa / MasterCard / Discover / American Express
  - Card #:____________________________________ Exp. Date:__________ CVV:________
- □ **Dental Insurance:** We will file your insurance claim and we accept assignment of your insurance payment. You are responsible for your deductible and any portion the insurance does not cover at the time of service. You are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and us. **INITIAL:___________ DATE:________**

Authorization:
I hereby certify the above statements are correct to the best of my knowledge. I hereby authorize payment of dental insurance benefits directly to the dental office, otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedure as may be necessary for proper dental care.

Signature of Responsibility:

X____ Date: ___________________
□Patient □Parent (Mother/Father) □Spouse (Wife/Husband) □Guardian