Welcome

Schaefer Advanced Dentistry
Dr. David Schaefer

ABOUT YOU

Today's Date: _____/_____/_____
Patient Name:_____
Last First MI
Name you prefer to be called:_____
Birthdate: _____/_____/_____ Age: _____
Social Security Number: _____
Mailing Address: _____

_____
City State Zip
Home Phone: _____
Cell Phone: _____
Work Phone: _____
E-mail Address: _____
Referred By: _____
Employer: _____How long?____
Occupation:_____
Status:_Minor__Single__Married__Divorced__Seperated__Widowed
Spouse's Name:_____
Do you have children? __Yes__No How many?_____

INSURANCE INFO

INSURANCE INFORMATION:

PLEASE PRESENT YOUR INSURANCE CARD AT TIME OF VISIT

Primary Dental Insurance:

Insurance Company:_____
Name of Policy holder:_____
Insured's Date of birth: _____/_____/_____
Policy Number:_____
Group Number: _____
Social Security Number:_____
Insured's Employer:_____
Is there secondary Dental Insurance? ___yes ___no
If so Ins. Co Name_____

_____I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I authorize release of information to insurance company. I fully understand I am solely responsible for any balance not paid by my insurance company. We request that co-payments and/or full payments(should the insurance company require checks being sent to the insured directly) are paid at the time of service. Convenient payment plans are available if necessary.

Do you require Premedication before your dental visit? ____Yes ____No ____Unsure

Previous Dentist:_____
Phone Number**:**_____
Date of Last Dental Exam:_____/_____/_____

Rate 1-10: *(1-Worst, 10-Best)*
How important is your dental health? _____
How would you rate your current dental health?_____
How would you rate your smile?_____
If there was anything you could change about your smile what would it be?_____
_____
_____

Are you satisfied with how straight your teeth are?
____ Yes ____ No

Have you had Botox Therapy?_____

ACCOUNT INFO

Person ultimately responsible for account:
Name:_____
Relationship to patient:_____
Cell Phone:_____
Preferred Method of Payment:
_____ Cash_____Check _____Credit Card:
VISA/MC/DISC/AMX
Card No._____

Please note: A service charge of 1.5% per month (18% annually) will be applied to all past due accounts. There will be a $25.00 service charge applied to all returned checks. Should my account go into collection procedures, I understand that Dr. Schaefer reserves the right to collect any fees incurred in the collection of my account, including but not limited to attorneys fees, collection agency fees and billing fees. There will be a $75.00 fee assessed for any late cancellations (24hours or less) or failed appointments.

TREATMENT AUTHORIZATION: I hereby authorize the above named dentist and staff to administer dental treatment to the best of their professional knowledge, and to administer such drugs or anesthetic agents as they deem necessary in said treatment or in an emergency situation.

Signature:_____
Date:_____