Russell M. Linman, DDS, MD ~ Edward C. Collins III, DDS, MS ~ Eric R. Schmidt, DMD

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PLEASE CHECK-IN ***15 BEFORE*** YOUR APPT TIME

Patient Name:_____ DOB:_____ Appointment Date:_____ Time:_____ am/pm

Health History

Pre-Med: _____
Taken at: _____
Dosage: _____

1. What is your impression of your present health? (circle one) Good Fair Poor
2. Year of your last medical physical? _____
3. Please circle any of the following which you have had or have at present.

Heart Disease or Condition	Stroke	Tuberculosis (TB)	Fainting or Dizzy Spells	Radiation Therapy
Angina	Hemophilia	Diabetes	AIDS or AIDS Related Complex	Chemotherapy
Frequent Chest Pains	Bruise Easily	Ulcers	HIV positive	Implant Prosthesis
High Blood Pressure	Prolonged/Unusual Bleeding	Kidney Trouble	Cold Sores	Unexplained weight loss
Shortness of Breath	Anemia	Liver Disease	Genital Herpes	Rheumatic Fever
Swollen Ankles	Blood Transfusion	Jaundice	Recurrent Infections	Emphysema
Artificial Heart Valve	Sickle Cell Disease	Stomach Ulcers	Anxiety/Nervous Disorder	Epilepsy or Seizures
Congenital Heart Disease	Arthritis	Acid Reflux	Venereal Disease (Syphilis/Gonorrhea)	Any disease, drug, or transplant
Heart Murmur	Lung Disease	Hepatitis	Drug Addiction/Abuse	that has depressed your
Pacemaker	Asthma	Thyroid Disease	Psychiatric Treatment	immune system.
Heart Surgery	Hay Fever	Glaucoma	Cancer	

Office Use Only: _____

_____

_____

Check yes or no for the following questions. If yes, please give details. (If in doubt, check yes)

___Yes ___No 4. Are you presently or have you been under the care of a physician during the past year? _____
___Yes ___No 5. Are you presently taking any medications or drugs? List: _____
___Yes ___No 6. Are you or have you ever taken any medications for osteoporosis? _____
___Yes ___No 7. Are you allergic to any MEDICATION or MATERIALS (latex or rubber products)? _____
___Yes ___No 8. Have you ever had a reaction to a local anesthetic? _____
___Yes ___No 9. Have you ever experienced any complication or illness following a dental treatment? _____
___Yes ___No 10. Do you have any diseases or conditions not listed above? _____
___Yes ___No 11. Have you ever been told you were not eligible to be a blood donor? _____
___Yes ___No 12. Do you use tobacco? (If yes, please circle below and give frequency): Frequency: _____
SMOKE: Cigarettes/Cigars/Pipe SMOKELESS: Chewing tobacco/Snuff/Dip
___Yes ___No 13. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?
___Yes ___No 14. Do you wish to talk with the doctor privately about anything?

FOR WOMEN ONLY:

___Yes ___No 15. Are you pregnant? If yes, circle the correct trimester? 1 2 3

A. If you are using oral contraceptives, it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed. Please consult with your physician for further guidance.

B. If you are pregnant, possibly pregnant, or trying to become pregnant, surgery, anesthetics, or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of you being pregnant.

Acknowledgment of Receipt of Notice of Privacy Practices

I have been offered a copy of this office's Notice of Privacy Practices. You may disclose information to my family members and or non-family members I have listed below. You may leave messages containing protected health information on my voicemail: ___Yes ___No

1. _____ 2. _____ 3. _____

Post-Operative Pain Management Contract

Opioid (narcotic) medications are highly addictive. You **MUST** disclose **ALL** *narcotic* medications that you have taken or been prescribed by **ANY** office in the 30 days prior to your surgery. Failure to do so will be interpreted as potential drug-seeking behavior, and all prescriptions for narcotic medications may be denied by this office. List narcotics taken & prescribed in the past month: _____

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

Date: _____ Referring Dentist: _____ Patient/Guardian Signature: _____ Dr._____

Patient Information

Name: Miss Mrs. Mr. _____
First Middle Last

Home Address: _____
Address City State ZIP

Phone: _____ _____ _____
Home Cell Business

Birthdate: _____ Age: _____ SS#: _____ Marital Status: Married Single Divorced Widowed

Occupation/School: _____ Gender: M F Employer: _____

Name of Spouse or Responsible Party (parent or guardian)

Name: Miss Mrs. Mr. _____
First Middle Last

Home Address: _____
Address City State ZIP

Phone: _____ _____ _____
Home Cell Business

Birthdate: _____ Age: _____ SS#: _____ Marital Status: Married Single Divorced Widowed

Occupation/School: _____ Gender: M F Employer: _____

☐ **No Ins** **Insurance Information** (Please complete or be prepared to pay in full)

Dental Insurance – Primary

Insured's Name: Miss Mrs. Mr. _____
First Middle Last

Home Address: _____
Address City State ZIP

Phone: _____ _____ _____
Home Cell Business

Birthdate: _____ Age: _____ SS#: _____ Marital Status: Married Single Divorced Widowed

Relationship to Patient: Self Spouse Parent Gender: M F Employer: _____

Insurance Co Name: _____ ID # _____ Group# _____

Insurance Co Address: _____

Dental Insurance – Secondary

Insured's Name: Miss Mrs. Mr. _____
First Middle Last

Home Address: _____
Address City State ZIP

Phone: _____ _____ _____
Home Cell Business

Birthdate: _____ Age: _____ SS#: _____ Marital Status: Married Single Divorced Widowed

Relationship to Patient: Self Spouse Parent Gender: M F Employer: _____

Insurance Co Name: _____ ID # _____ Group# _____

Insurance Co Address: _____

Medical Insurance – Primary

Insured's Name: Miss Mrs. Mr. _____
First Middle Last

Home Address: _____
Address City State ZIP

Phone: _____ _____ _____
Home Cell Business

Birthdate: _____ Age: _____ SS#: _____ Marital Status: Married Single Divorced Widowed

Relationship to Patient: Self Spouse Parent Gender: M F Employer: _____

Insurance Co Name: _____ ID # _____ Group# _____

Insurance Co Address: _____

How will you be paying today (please circle one)?

Cash Check (DL# & Phone# on check) Credit Card (Visa/MC/Disc/AmEx) Flex HSA Care Credit (Cardholder Must Be Present, 2 Forms of ID Required)