



We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called _____ [] Male [] Female
[] Single [] Married [] Child [] Other Birth date: ___/___/___ Age: _____ S.S. #: _____
Home Address: _____ City _____ State _____ Zip _____
Home Phone: (____) _____ Work: (____) _____ ext. ____ Pager: (____) _____
Cell: (____) _____ E-mail Address: _____
Employer: _____ How long there? _____ Occupation: _____
Employer's Address: _____ City _____ State _____ Zip _____

PERSON RESPONSIBLE FOR ACCOUNT (if other than yourself)

[] Same as above Name: _____ Birth date: ___/___/___ Relation: _____
Billing Address: _____ City _____ State _____ Zip _____
Home Phone: (____) _____ Work: (____) _____ S.S. #: _____
Employer: _____ How long there? _____ Occupation: _____

SPOUSE INFORMATION

[] Same as above Name: _____ Birth date: ___/___/___
Employer: _____ Work Phone: (____) _____ ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____
Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____
Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____
Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____
Insured's Social Security #: _____ Insured's Employer: _____



MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: (____) _____

Do you have or have ever had any of the following? Please check those that apply:

- [] Allergies/Hay Fever [] Diabetes [] Heart Surgery* [] Rheumatic Fever
[] Anemia [] Epilepsy or Seizures [] Hepatitis [] Rheumatism
[] Angina [] Excessive Thirst [] High Blood Pressure [] Sickle Cell Disease
[] Arthritis [] Fainting or Dizziness [] HIV*/AIDS [] Sinus Problems
[] Artificial Joints* [] Fever Blisters/Cold Sores [] Kidney Problems [] Stroke
[] Artificial Heart Valves* [] Frequent Cough [] Liver Problems [] Surgical Shunt*
[] Asthma [] Glaucoma [] Mental Disorders [] Thyroid Problems
[] Breathing Problems [] Heart Disorder (Congenital)* [] Mitral Valve Prolapse* [] Tuberculosis
[] Cancer [] Heart Infection* [] Osteoporosis [] Ulcers
[] Chemical Dependency [] Heart Murmur* [] Radiation Treatment [] Venereal Disease
[] Chemotherapy [] Heart Pace Maker* [] Respiratory Problems [] Yellow Jaundice

* This condition may require antibiotic premedication for certain dental procedures.

YES NO

- [] [] Do you have any health problems that were not listed above or need further clarifications?
If yes, explain: _____
[] [] Are you now under the care of a physician? If yes, explain: _____
[] [] Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, explain: _____
[] [] Are you taking any medications or herbals? If yes, list: _____
[] [] Are you allergic to any medications or substances? If yes, please check box below:
[] Aspirin [] Penicillin [] Codeine [] Iodine [] Metal [] Latex [] Other _____
[] [] Have you used tobacco? If yes, explain: _____

WOMEN (Please check): [] Pregnant [] Trying to get pregnant [] Nursing [] Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X _____ Date _____
Signature of patient, parent or guardian

MEDICAL UPDATES (for future use)

I have read my MEDICAL HISTORY dated _____ and confirm that it states past and present conditions.

Date: _____ Exceptions: _____ Patient's Signature:
_____ [] None X _____
_____ [] None X _____
_____ [] None X _____



DENTAL HEALTH QUESTIONNAIRE

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan. We will perform a **comprehensive oral examination** of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern. Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there. We will review our findings with you and discuss your treatment options. A **personalized treatment plan** will then be developed to help you achieve the goals we set together.

Please help us better understand your dental health needs and goals by answering the following questions (check the best answer):

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years? **Yes** **No**
2. I have a **low** **moderate** **high** fear of going to the dentist.
3. My mouth and teeth are **very** **moderately** **not** comfortable.
4. I am **very satisfied** **satisfied** **dissatisfied** with the appearance of my teeth.
5. I think my present state of dental health is **excellent** **good** **fair** **poor**.
6. I would say that my main concerns with my dental health are: _____
7. I am interested in a smile evaluation and personalized treatment plan to enhance my smile. Yes No
8. Please check which statement below best represents the level of dental health you wish to achieve.
(*It is not uncommon for people to begin at one level and progress to a higher level over time.*)

HEALTH LEVEL I - Emergency Care

I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment.
I am not very interested in thinking about the future of my teeth at this time.

HEALTH LEVEL II - Maintenance Care

I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

HEALTH LEVEL III - Comprehensive Care

I am interested in comprehensive care to achieve and maintain a higher level of dental health.
I am concerned about treating the causes of dental diseases, not simply the effects.
I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

HEALTH LEVEL IV - Comprehensive & Cosmetic Care

I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health.
I am concerned about treating the causes of dental diseases, not imply the effects.
I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, so as to achieve long-term stable, yet esthetic, dental health.



APPOINTMENTS

We value your time, please value ours. Because we recognize the value of your time, you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Also, please make every effort not to change your schedule appointment. If you find you must change an appointment, please provide us at least **48 hour advanced notification** so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. An **hourly charge** may be applied for broken or missed appointments without adequate advanced notifications. Thank you for your cooperation in this matter.

FINANCIAL POLICY

- Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment.
- For procedures longer than 1 HOUR, 1/3 down is expected to reserve the appointment time.

Payment Options

1. For your convenience we accept Cash, Check, Visa, MC, American Express and Discover.
2. We also offer short and long-term financing through Citi Health Card and Wells Fargo (12 months interest free financing may apply)

For patients with Dental Insurance

A. Patient chooses to pay in full for all treatment and will accept the offer from Mandeville Center for Dental Excellence to electronically file patients claim with the insurance carrier for direct reimbursement to the patient.

B. Patient agrees to pay a deposit for all treatment and will accept the offer from Mandeville Center for Dental Excellence to electronically file and accept payments from insurance carrier. Patient understands to receive this benefit, patient's credit card information will be needed to guarantee the account. Patient understands that as soon as the insurance carrier issues a payment, or 90 days, the unpaid portion of the claim will be charged to patient's credit card without penalty or interest. Patient understands that if for some reason the credit card is not available for covering the treatment balance, patient is responsible for payment with interest and penalties.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Schof. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Schof to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Schof.

Photography Release

I authorize Dr. Schof to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options (*as you may be shown photographs for the same reason*).

My signature acknowledges that:

- I understand and will comply with office **Appointment Policy**.
- I understand and will comply with the office **Financial Policy**.
- I understand and agree to the **General Consent to Treatment**.
- I authorize the **Release of Information**.
- I authorize **Photographs** to be taken of me and shown to other patients.
- I have received a copy of the office's **Notice of Privacy Practices**.

X _____ Date _____
Signature of patient, parent or guardian



SCREENING QUESTIONS FOR BITE PROBLEMS

Name: _____ Date: _____

Yes No

- | | | | |
|--------------------------|--------------------------|-----|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. | Do you have difficulty or pain when opening your mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. | Does your jaw "get stuck", "lock", or "go out"? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. | Do you have difficulty or pain when chewing, talking, or using your jaws? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. | Are you aware of noises in the jaw? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. | Do your jaws regularly feel stiff, tight or tired? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. | Do you have pain in or about the ears, temples or cheeks? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. | Do you have frequent headaches, neck aches, or toothaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. | Have you had a recent injury to your head, neck or jaw? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. | Have you been aware of any recent changes in your bite? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. | Have you been previously treated for unexplained facial pain or a jaw joint? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. | Do you have any problems chewing bagels, protein bars or anything chewy? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. | Do you have problems chewing gum? Does it hurt your jaw or jaw joint? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. | Have your teeth changed in the last 5 years? (wear, shorter, thinner, open spaces, looseness) |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. | Do you have more than one bite? |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. | Do you sleep restlessly? |



NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices.

I understand that I may ask any questions I may have regarding this notice.

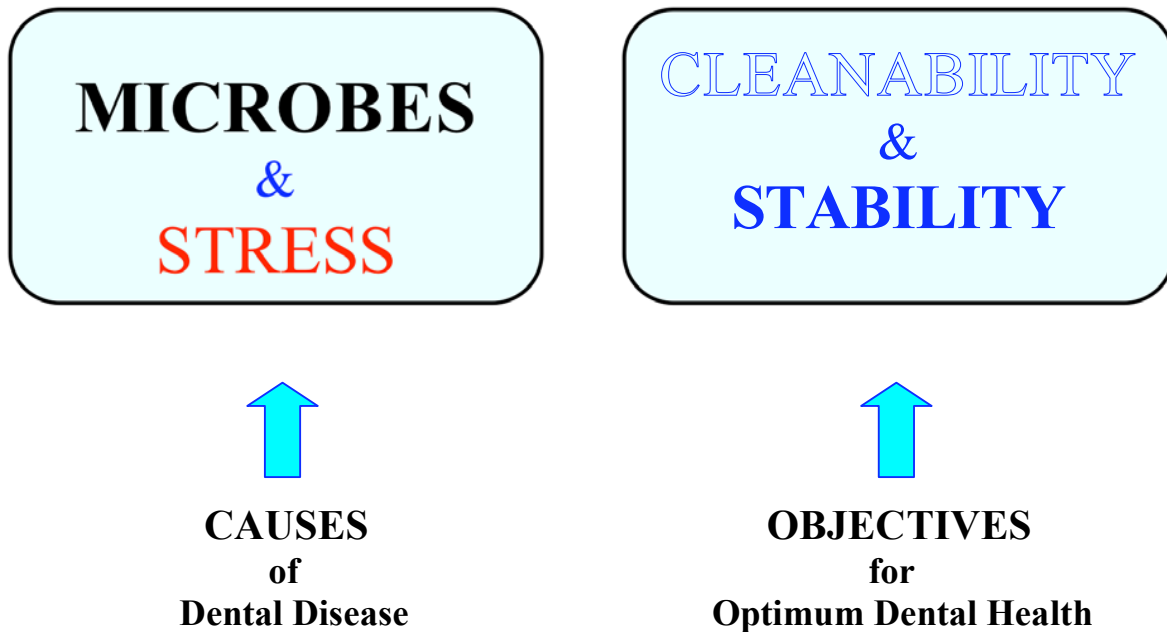
Signature _____ Date _____



Charles A. Schof, D.D.S.

My goal is to help you achieve *optimum dental health*.

OPTIMUM DENTAL HEALTH is the predictable absence of dental disease by the identification and elimination of disease-causing factors.



KEY POINT

If we are to make your mouth healthy and keep it that way, we must accomplish two things:

1. We must leave no place in your mouth that is not completely cleanable.
2. We must reduce all the stresses in your mouth to a point where they are not destructive.