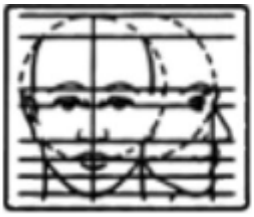

Schneider Oral Surgery

Oral, Facial and Implant Surgery

11030 N. Tatum Blvd
Ste F100
Phoenix, AZ 85028
(602) 996-2225

Patient Information

First Name _____ MI ___ Last Name _____ Age ___

Birth Date _____ Address _____

City _____ State ___ Zip _____

Cell _____ Work _____ Email _____

Emergency Contact _____ Phone _____

Referred By _____

Person responsible for payment _____ Relationship _____

Address if different from patient _____ Phone _____

Intended method of payment ☐ Check ☐ Visa ☐ Mastercard ☐ Discover ☐ Cash

Insurance Information ☐None

Dental Insurance _____ Group No. _____

Subscriber _____ ID/SSN _____

Birthdate _____ Subscriber Employer _____

Health History

Have you had or do you currently have...

Yes	No		Yes	No	
☐	☐	Rheumatic fever?	☐	☐	Diabetes?
☐	☐	Heart murmur?	☐	☐	Kidney trouble?
☐	☐	High blood pressure?	☐	☐	Stomach ulcers?
☐	☐	Chest pain/angina?	☐	☐	Sexually transmitted diseases?
☐	☐	Irregular heartbeat?	☐	☐	Problems with the immune system?
☐	☐	Heart surgery/Heart valve surgery?	☐	☐	A tumor or growth?
☐	☐	Asthma?	☐	☐	Radiation treatment/chemotherapy?
☐	☐	Hay fever/sinus problems?	☐	☐	A history of drug use?
☐	☐	Difficulty breathing/other lung trouble?	☐	☐	A history of alcohol abuse?
☐	☐	Do you smoke? ☐ Tobacco ☐ Marijuana	☐	☐	Sleep apnea?
☐	☐	Bleeding tendency/abnormal bleeding?	☐	☐	Mental health problems?
☐	☐	Jaundice/hepatitis/liver disease?	☐	☐	Pain or clicking of the jaws/TMJ?
☐	☐	Osteoporosis?	☐	☐	Problems with general anesthesia?
☐	☐	Convulsions/epilepsy?	☐	☐	Malignant hyperthermia?
☐	☐	Thyroid trouble?			

Family Health History

Is there a family history of...

Yes No

- ☐ ☐ Oral Cancer?
- ☐ ☐ Heart disease?
- ☐ ☐ Malignant Hyperthermia?

Women's Health

Yes No

- ☐ ☐ Is there a possibility of pregnancy?
- ☐ ☐ Are you nursing?
- ☐ ☐ Are you taking birth control pills?

Pharmacy

Name _____ Address _____ Phone _____

Medications ☐ None

_____ _____

_____ _____

_____ _____

_____ _____

Medication Allergies ☐ None

_____

_____

_____

_____

Prior Surgeries ☐ None

_____

_____

_____

_____

I HAVE ANSWERED THE ABOVE QUESTIONS ACCURATELY AND TO THE BEST OF MY KNOWLDEGE.

Signature _____ Date _____

I authorize Dr. Brian R. Schneider and/or his employees to release my medical and treatment information to my health care providers and insurance providers to facilitate treatment and/or for my financial reimbursement. I also authorize Dr. Brian R. Schneider and/or his employees to share information with the following:

_____

Signature _____ Date _____

I authorize Dr. Brian R. Schneider and/or his employees to take my picture for record keeping by attaching to my chart and computer file.

Signature _____ Date _____

OFFICE USE ONLY

BP _____

Pulse _____

SpO2 _____

Height _____

Weight _____