



# White River Dentist

Richard Schramm, D.M.D.  
Tara Symancyk, D.D.S.  
Mark Klampert, D.D.S.

1049 N. Hartland Road, PO Box 948  
White River Jct, VT 05001-0948  
802-295-2458  
[info@whiteriverdentist.com](mailto:info@whiteriverdentist.com)

## PATIENT INFORMATION (Confidential)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_  
Home Cell Work

Patient employer: \_\_\_\_\_

Your E-Mail: \_\_\_\_\_

Married? Spouse's Name and Employer: \_\_\_\_\_

Minor? Parent or Guardian's Name, Address, and Phone: \_\_\_\_\_

College? \_\_\_\_\_ Full time \_\_\_\_\_ Part time Name of School: \_\_\_\_\_

School's Address: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Person to contact IN CASE OF EMERGENCY: \_\_\_\_\_ Phone: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Same as above

Name of person responsible for this account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Birth date: \_\_\_\_\_

\_\_\_\_\_ Social Security #: \_\_\_\_\_

Telephone: \_\_\_\_\_  
Home Cell Work

Drivers License#: \_\_\_\_\_ State: \_\_\_\_\_

Is the responsible party a current patient in this office? \_\_\_\_\_ YES \_\_\_\_\_ NO

## DENTAL INSURANCE INFORMATION

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birth date of Policy Holder: \_\_\_\_\_ Social Security # of Policy Holder: \_\_\_\_\_

ID# of Policy Holder: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Do you have additional Dental Insurance?  YES  NO If yes complete the following:

Name of Policy Holder: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Birth date of Policy Holder: \_\_\_\_\_ Social Security # of Policy Holder: \_\_\_\_\_

ID#: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_



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## Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of White River Dentist ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means the patient.

### II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact White River Dentist's Privacy Official at:

Lori Fernandes

P.O. Box 948 1049 North Hartland Road

White River Junction, Vermont 05001

802-295-2458

802-295-3985

[info@whiteriverdentist.com](mailto:info@whiteriverdentist.com)

### III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

### IV. Last Revision Date

This Notice was last revised in June 2013

### V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

#### A. Common Uses and Disclosures

**1. Treatment.** We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

**2. Payment.** We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

**3. Health Care Operations.** We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

**4. Appointment Reminders.** We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

**5. Treatment Alternatives and Health-Related Benefits and Services.** We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

**6. Disclosure to Family Members and Friends.** We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

**7. Disclosure to Business Associates.** We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

## **B. Less Common Uses and Disclosures**

**1. Disclosures Required by Law.** We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

**2. Public Health Activities.** We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**3. Victims of Abuse, Neglect or Domestic Violence.** We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

**4. Health Oversight Activities.** We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

**5. Lawsuits and Legal Actions.** We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

**6. Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

**7. Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

**8. Organ, Eye and Tissue Donation.** We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

**9. Research Purposes.** We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

**10. Serious Threat to Health or Safety.** We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

**11. Specialized Government Functions.** We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

**12. Workers' Compensation.** We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

## **VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information**

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made

only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

## **VII. Your Rights with Respect to Your Health Information**

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

### **A. Right to Access and Review**

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

### **B. Right to Amend**

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

### **C. Right to Restrict Use and Disclosure**

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

### **D. Right to Confidential Communications, Alternative Means and Locations**

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

### **E. Right to an Accounting of Disclosures**

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

### **F. Right to a Paper Copy of this Notice**

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

### **G. Right to Receive Notification of a Security Breach**

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

## **VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information**

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and

genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

#### **IX. Our Right to Change Our Privacy Practices and This Notice**

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is June 2013

#### **X. How to Make Privacy Complaints**

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.



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## Acknowledgement of Receipt of Notice of Privacy Policies

### *Your Privacy Is Important to Us*

I have received a copy of the Notice of Privacy Practices of Drs. Schramm, Symancyk, and Klampert. I hereby authorize, as indicated by my signature below, Drs. Klampert, Schramm, and Symancyk to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

\_\_\_\_\_

Print Name

\_\_\_\_\_

Address

\_\_\_\_\_

Signature of patient, parent, or guardian

\_\_\_\_\_

Date

#### Means of communication:

My home phone number is \_\_\_\_\_

My cell phone number is \_\_\_\_\_

My work phone number is \_\_\_\_\_

My email is \_\_\_\_\_

Other \_\_\_\_\_

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_

2. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_

3. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_

\*\*\*

#### For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please Specify) \_\_\_\_\_

Staff Person Initials \_\_\_\_\_



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## OFFICE POLICY REGARDING APPOINTMENTS FOR VERMONT MEDICAID RECIPIENTS

Thank you for choosing our office to help serve your dental needs. We look forward to working with you to better your dental health and to help you maintain a healthy smile. We accept appointments by reservation only. Our office hours are Monday through Thursday from 8am to 5pm and Friday from 8am to 12pm.

Every effort is made to keep on schedule, and we respectfully ask you to arrive on time for your appointment. We try to remind you of your appointment by your preferred means of communication. However, this is a courtesy only. If we are unable to contact you, your appointment card will serve as confirmation, and implies your obligation to be present. Vermont Medicaid recipients who miss an appointment, or break an appointment without a 1 business day notice will not be allowed to reschedule using your Vermont Medicaid plan.

Please be sure to check in with the front office coordinators upon your arrival. They will verify your information on file. We ask that you provide us with up to date address and contact information. Please be sure to bring your Vermont Medicaid card if you would like us to assist in filing your dental insurance claims. Please advise us immediately of any insurance coverage changes, exclusions or waiting periods.

If you have been waiting more than 20 minutes past your scheduled appointment time, please notify one of the scheduling coordinators. On the rare occasion that we do run late, we ask your patience and understanding. We will do our best to complete your scheduled treatment on time. Above all, your dental health and comfort is our main concern, and we will give you the individual attention necessary to complete your treatment.

I understand that once my annual benefits have been completed and used (maxed out) for the year, I accept full financial responsibility for all fees for further treatment and agree to pay White River Dentist any balance not covered by Vermont Medicaid for services rendered on the day of treatment.

Please advise us immediately of any circumstances that will interfere with your appointments. We look forward to working with you to better your dental health and to help you maintain a healthy smile.

I have read and understand the office policy above. I authorize Dr. Schramm, Dr. Symancyk, Dr. Klampert and their staff to proceed with my/my child's dental treatment.

Print name \_\_\_\_\_

Signature of patient or parent of minor \_\_\_\_\_

Date \_\_\_\_\_



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## PATIENT CONSENT

### Clinical

1. I authorize Drs. Schramm, Symancyk, and Klampert to perform all recommended treatment with my permission.
2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.
3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

### Financial

1. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18%APR may be automatically tabulated into my account if my balance is 30 days old or older. A \$10.00 billing fee will also be added to your account if a balance is 30 days or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees. Please be aware that if there is a balance due on your account, we will not be able to schedule any further appointments until your balance is paid in full.
2. A \$50.00 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, a 24 hours notice of cancellation is required.

### Insurance

1. I authorize the Practice to release to staff, hospitals, healthcare service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
2. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

**I have read this Patient Consent and agree to all terms and conditions herein.**

Patient's Name: \_\_\_\_\_

Signature of patient, parent, or guardian: \_\_\_\_\_ Date: \_\_\_\_\_





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## MEDICAL HISTORY

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	YES	NO
Are you under a physician's care now?		If yes, please explain:
Have you ever been hospitalized or had a major operation		If yes, please explain:
Have you ever had a serious head or neck injury		If yes, please explain:
Are you taking any medication, pills, or drugs		If yes, please fill out additional form (Medication List)
Do you take, or have you taken, Phen-Fen or Redux		
Have you ever taken Fosamax, Bonivea, Actonel or any other medications containing Bisphosphonates		
Are you on a special diet		
Do you use tobacco		
Do you use controlled substances		

### Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs

Other, please explain: \_\_\_\_\_

### Women: are you

Pregnant/trying to get pregnant?  YES  NO      Taking Oral contraceptives?  Yes  NO

Nursing?  YES  NO



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## MEDICAL HISTORY

Do you have, or have you had, any of the following?

	YES	NO		YES	NO		YES	NO
Acid Reflux/Bulimia			Excessive Bleeding			Lung Disease		
AIDs/HIV Positive			Excessive Thirst			Mitral Valve Prolapse		
Alzheimer's Disease			Fainting/Dizzy Spells			Osteoporosis		
Anaphylaxis			Frequent Cough			Pain in Jaw Joints		
Anemia			Frequent Diarrhea			Parathyroid Disease		
Angina			Frequent Headaches			Psychiatric Care		
Arthritis/Gout			Genital Herpes			Radiation Treatments		
Artificial Heart Valve			Glaucoma			Recent Weight Loss		
Artificial Joint			Hay Fever			Renal Dialysis		
Asthma			Heart Attack/Failure			Rheumatic Fever		
Blood disease			Heart Murmur			Rheumatism		
Blood Transfusion			Heart Pacemaker			Scarlet Fever		
Breathing Problem			Heart Trouble/Disease			Shingles		
Bruise Easy			Hemophilia			Sickle Cell Disease		
Cancer			Hepatitis A			Sinus Trouble		
Chemotherapy			Hepatitis B or C			Spina Bifida		
Chest Pains			Herpes			Stomach/Intestinal Disease		
Cold Sores/Fever blisters			High Blood Pressure			Stroke		
Congenital Heart Disorder			High Cholesterol			Swelling of Limbs		
Convulsions			Hives or Rash			Thyroid Disease		
Cortisone Medicine			Hypoglycemia			Tonsillitis		
Diabetes			Irregular Heartbeat			Tuberculosis		
Drug Addiction			Kidney Problems			Tumors or Growths		
Easily Winded			Leukemia			Ulcers		
Emphysema			Liver Disease			Venereal disease		
Epilepsy or Seizures			Low Blood Pressure			Yellow Jaundice		
Have you ever had any serious illness not listed above?	YES	NO				If yes please list below		

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian \_\_\_\_\_ Date \_\_\_\_\_



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## MEDICATION LIST

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Medication Name:	Dosage and Frequency:	Reason for Use:

Date: \_\_\_\_\_



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## DENTAL HISTORY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

What would you like to address: \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_ Previous dentist: \_\_\_\_\_

Any previous major dental treatment:  Yes  No When: \_\_\_\_\_ Why: \_\_\_\_\_

### DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING:

YES	NO	YES	NO	YES	NO
Teeth sensitive to brushing or flossing	Bad Breath	Cigarettes, pipe or cigar smoking			
Bleeding gums, since when	Unpleasant taste	Bleeding gums when brushing or flossing			
Food stuck between teeth	Unfavorable dental experiences	Toothbrush, how often			
Clenching or grinding teeth	Complication from extractions	Dental floss, how often			
Burning of tongue	Periodontal treatment	Inter dental stimulators, how often			
Swelling or lumps in mouth	Orthodontic treatment	Water jet device, how often			
Frequent blisters on lips or mouth	Mouth breathing	Disclosing tables or solution, how often			
Pain around ear	Oral habits, i.e. fingernail biting, cheek biting, etc.	Fluoride supplements, how often			
Unusual sounds in ear while eating	Tender or swollen gums	Mouthwash, how often			
Teeth sensitive to hot	Tired jaw muscles	Lose or break fillings easily			
Teeth sensitive to cold	Dentures	Gag easily			
Teeth sensitive to sweets	Many cavities	Preventative dentistry			
Teeth sensitive to pressure	Many fillings	Chew on one side of the mouth			

What type of toothbrush do you use:

Soft  Medium  Hard  Nylon  Natural

Do you want a fluoride supplement:

Yes  No

Do you want to be taught preventative dental hygiene:

Yes  No

Are you unusually nervous about dental visits:

Yes  No

Do you want to save your remaining teeth:

Yes  No

Is there anything you would like to add:

\_\_\_\_\_  
\_\_\_\_\_



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## RECORDS RELEASE AUTHORIZATION

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize and request you to send:

White River Dentist  
PO Box 948  
White River Jct, VT 05001-0948  
802-295-2458  
[info@whiteriverdentist.com](mailto:info@whiteriverdentist.com)

All dental records and x-rays in your possession, for the continuance of my/my child's dental care.  
Please email, if possible. Thank you.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**\*\*IMPORTANT: PLEASE HAVE YOUR X-RAYS AND TREATMENT HISTORY SENT TO OUR OFFICE PRIOR TO YOUR DENTAL APPOINTMENT. DUPLICATE X-RAYS TAKEN MAY BE AT YOUR EXPENSE.**