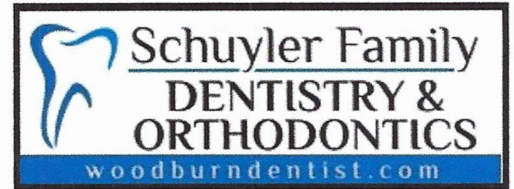
Welcome to Our Practice!



Thank you for selecting our dental healthcare team! We will constantly strive to provide you with the best possible dental care.

Patient Information

Name: ________________________________ Name Preference: ________________

Address: ______________________________ City: ____________ State/Zip: ________

Home Phone: ________________ Cell Phone: ________________ Date of Birth: ________

Social security #: __________________ Drivers License #: ________________________

Employer: ________________________________ Work Phone: ___________________

Email: _________________________

Would you like to receive email/text message correspondence (appointment confirmations)?

☐ Yes, I would like to receive text messages ☐ Yes, I would like to receive emails ☐ Neither

Emergency Contact: ____________________ Relationship: _______ Phone: ___________

How did you hear about us? ____

Whom may we thank for referring you to our office? ______________________________

Responsible Party(if different from above)

Name: ________________________________ Relationship to Patient: ______________

Address: ____________________________ City: ____________ State/Zip: __________

Home Phone: ________________________________ Date of Birth: ________________

Employer: ____________________________ Social Security #: __________________

Insurance Information

Insurance Co.: ____________________________ Phone Number: __________________

Address: ___________________________ City: ____________ State/Zip: ___________

Name of Policy Holder: ___________________________ Date of Birth: _______________

Social Security # or ID #: _________________________ Group #: __________________

Secondary Insurance Information

Insurance Co.: __________________________ Phone Number: _____________________

Address: ____________________________ City: _____________ State/Zip: ________

Name of Policy Holder: ____________________________ Date of Birth: ____________

Social Security # or ID #: _________________________ Group #: __________________

I understand I am responsible for any amount not covered by my dental insurance. I hereby authorize payment directly to Doctor Schuyler for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and /or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistant and other medical personnel. I have been given and reviewed a copy of "Notice of Privacy Practices" for the office of Dr. Schuyler.

Signature of the Insured ______________________________ Date ____________

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

Question	Answer	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:

X

Date:__________

Schuyler Family Dentistry, P.C.

1325 North Pacific Highway, Woodburn, Oregon 97071.
www.schuylerfamilydentistry.com
503-982-5315

First Name	Middle Initial	Last Name

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score
TOTAL the values from all 8 questions,
If 11 or less
Score = 0
If 12 or more
Score = 2

Score

Frequency | **0 - 1 times/week** | **1 - 2 times/week** | **3 - 4 times/week** | **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

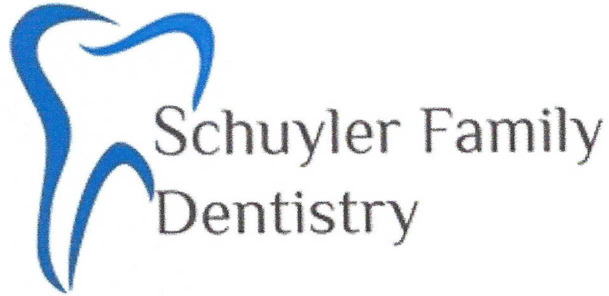
Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code	Phone Number	Total all 6 boxes from above	Point Total
			If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	



Records Release Form

Date: __________

To: Dr___________________________

Address:_________________________

City/State/Zip:_____________________

I, _______________________ authorize the release of my Dental Xrays, Perio charting, and Dental Records to be transferred to:

Joshua Schuyler, D.M.D
1325 N. Pacific Hwy.
Woodburn, Oregon 97071
Phone: 503-982-5315 Fax: 855 815-7466

Other Family members to transfer: ________________

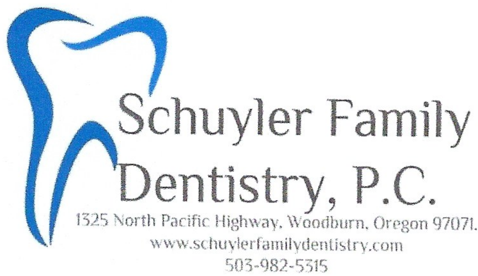
Signed:_______________________________ **DOB**:_____________

Print name and address:_______________________

____

____

- If xrays are digital please email to : office @schuylerfamilydental.com
- Please list last exam, bitewing and cleaning and dates of any crowns, bridges, partials, or dentures seated.



Patient Financial Policy

Schuyler Family Dentistry's primary responsibility is to help our patients maintain good oral health. In the interest of good oral health practice, our office has established a credit policy to help patients understand their financial responsibility while receiving optimal patient care.

1. **ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF YOUR VISIT, UNLESS SATISFACTORY ARRANGEMENTS HAVE BEEN MADE.** On accounts which have established arrangements the payment is due upon receipt of the monthly statement. Any balance outstanding more than 60 days will bear interest of 2%, or a minimum of $2.00, per month.

2. Payment options are: ***CASH, CHECK, VISA/MASTERCARD, DISCOVER, AMERICAN EXPRESS, OR CARE CREDIT.*** (Care Credit is a line of credit which has no down payment, no annual fee or prepayment penalties, and a low monthly payments interest free. Interest is charged retroactively if the account is not paid in full in the allotted time. Patients are held accountable by Care Credit and are therefore responsible for reading and following the terms of the agreement.)

3. ***DENTAL INSURANCE*** is billed as a courtesy to our patients. Even though you may have an insurance claim pending, you will receive a monthly statement showing a balance due on your account. WE CANNOT accept responsibility for collection of an insurance claim after 90 days, or negotiating a disputed claim. INSURANCE REIMBURSEMENT IS A CONTRACT BETWEEN YOU AND THE INSURANCE CARRIER. Ultimately, the patient is responsible for payment on their account.

4. **THERE WILL BE A $60.00 CHARGE FOR ALL APPOINTMENTS THAT ARE BROKEN OR CANCELLED WITHOUT A 24 HOUR NOTICE.**

I have read this office and credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment on my account. I understand that delinquent accounts may be assigned to a credit reporting collection service and I will be charged a $50 collection fee. Also, if it becomes necessary to turn my account over to the collection agency, I agree to pay for all costs, expenses, including Attorney Fees. I hereby authorize the Dr. Schuyler to release information necessary to secure payment.

Patient Name:____

Guarantor Signature:_____________________________ Date__________