



Brick Walk Esthetic Dentistry
Functional Esthetic Dentistry

Ben Schultz, DDS, MAGD
Master, Academy of General Dentistry
1275 Post Rd., Ste. 2
Fairfield, CT 06824
203-319-9998
www.drbenchultz.com

Patient Information and Health History

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Business Phone _____
Occupation _____ Employer _____
Business Address _____ City _____ State _____ Zip _____
Birth Date _____ Gender _____ Social Security Number _____
Marital Status _____ Spouse's Name _____
How did you hear about our office? _____

Financial Information

Terms of payment: Cash _____ Check _____ MC/Visa/Amex _____ Financing _____
Primary dental insurance _____
Employee _____ Date employed _____
Membership Number _____ Social Security Number _____
Secondary insurance carrier _____
Employee _____ Date employed _____
Membership number _____ Social Security Number _____

Emergency Contact (Not Living With You)

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Phone _____

I understand that dental treatment is an agreement between Brick Walk Esthetic Dentistry and myself, and that payment is due as services are rendered. I also understand and agree that **I am financially and legally responsible for full payment of my bill** and that *failure of my insurance carrier to pay for its portion of my bill does not constitute a reason for me to refuse to pay.* I understand that my insurance policy is a contract between my employer and the carrier, and that Brick Walk Esthetic Dentistry is not responsible for settling any disputed claims. The office will provide information to the insurance company regarding my treatment in order to facilitate the payment for the benefits to which I am entitled.

I understand that an appointment at Brick Walk Esthetic Dentistry is a value reserved exclusively for me at that time. I realize that, as a responsible person who cares about my dental health, I will be charged for late cancellations or missed appointments. I understand that all **accounts sixty days past due will bear interest at the rate of 21% per year**, and in the event that my account is referred for collection due to default of payment I agree to pay all costs of collection, including filing fees, court costs, and all fees as allowed by law.

Signature (Patient/Guardian)

Date

- 1. Are you having pain or discomfort at this time? Yes No
- 2. Do you usually feel very nervous about having dental treatment?..... Yes No
- 3. Name of physician _____ City _____
- 4. Have you been a patient in a hospital in the last two years? _____
If yes, for what reason? _____
- 5. Do you smoke cigarettes? _____ How many packs per day? _____
- 6. Have you taken any medication or drugs in the past two years? _____ Are you currently taking any medication? _____

7. Circle any of the following to which you are allergic, or have had a bad reaction:

- | | | | |
|----------|---------------|-------------------|-------------------|
| Aspirin | Nitrous Oxide | Penicillin | local anesthetics |
| Vicodin | Laughing Gas | other antibiotics | novocaine |
| Codeine | Erythromycin | motrin(ibuprofen) | lidocaine |
| Percodan | Tetracycline | valium | Tylenol |

8. Are you aware of being allergic to any other medication or substance? If yes, please list _____

9. Circle any of the following which you have or have ever had:

- | | | | |
|--------------------------|--------------------|---------------------|-----------------------|
| Congestive Heart Failure | Stroke | Chemotherapy | Yellow Jaundice |
| Heart Attack | Kidney Trouble | Radiation Therapy | Blood Transfusion |
| Angina Pectoris | Ulcers | Cancer/Leukemia | Drug Addiction |
| High Blood Pressure | Cosmetic Surgery | Arthritis | Alcoholism |
| Heart Murmur | Bruise Easily | Rheumatism | Venereal Disease |
| Rheumatic Fever | Emphysema | Glaucoma | Cold Sores |
| Congenital Heart Lesions | Tuberculosis (TB) | Facial Pain | Fever Blisters |
| Mitral Valve Prolapse | Asthma | Pain in Jaw Joints | Epilepsy or Seizures |
| Scarlet Fever | Hay Fever | Recurrent Headaches | Fainting/Dizzy Spells |
| Artificial Heart Valve | Sinus Trouble | HIV+ | Nervousness |
| Heart Pacemaker | Allergies or Hives | AIDS | Psychiatric Treatment |
| Heart Surgery | Diabetes | Hepatitis A | Multiple Sclerosis |
| Artificial Joint | Thyroid Disease | Hepatitis B(serum) | Muscular Dystrophy |
| Anemia | Hemophilia | Liver Disease | Sickle Cell Disease |

10. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? _____

11. Do your ankles swell during the day? _____

12. Do you need more than two pillows to sleep? _____

13. Do you ever wake up from sleep short of breath? _____

14. Are you on a special diet? _____

15. Do you have any disease or condition not listed above? _____ Please list _____

16. **For Women Only:** Are you pregnant? _____ What Month? _____

Are you taking birth control pills? _____

To the best of my knowledge, the information on this page is true and complete.

Signature

Date



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ACKNOWLEDGEMENT of Receipt of PRIVACY PRACTICES And CONSENT for Use and DISCLOSURE of Health Information

****You May Refuse to Sign This Acknowledgement****

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Brick Walk Esthetic Dentistry, **Office Manager**

Telephone: **203-319-9998**

E-mail: **info@drbenschultz.com**

Address: **1275 Post Rd., Suite 2, Fairfield, CT 06824**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent. Upon revocation, we are no longer allowed to send your medical information or claims electronically.

I _____ have had the opportunity to read a copy of this office's **Notice of Privacy Practices** and understand my rights and responsibilities there under.

Signature

Date



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Photography Release

I, _____, hereby authorize Dr. Ben Schultz or his team members to take photographs, slides and/or videos of my face, jaws and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature

Date