DR. ASHLEY SCHWARK, DDS

Dental /Medical History

Date: _____

Personal

Social Security Number _____

Name _____ Nickname _____

Address: _____

City _____ State _____ Zip Code _____

Phone # _____ E-Mail _____

Occupation _____

Date of Birth _____ Male ❑ Female ❑

Weight _____ Height _____

Single ❑ Widowed ❑ Divorced ❑ Married ❑ Name of Spouse: _____

Emergency Contact: _____ Phone # _____

If completing this form for another person, what is your relationship? _____

How did you hear about us? _____

Insurance

Employer Name: _____ Dental Insurance Company _____

We will need to make a copy of your dental insurance card.

Dental

What is your chief dental complaint?

_____

When was your last dental visit?

_____

Have you had trouble associated with previous dental exam? If yes, please explain.

_____

_____

Do you suffer from bleeding gums? _____

Do you floss consistently? _____

Are you wearing removable dental appliances? _____

Do you have a particular problem you would like to discuss with the doctor?

_____

_____

Do you have ongoing dental treatment the dentist should be aware of and/or do you have dental history other than standard maintenance?

_____

_____

Have you ever had any dental surgeries (other than wisdom teeth removal)? If yes, please describe.

_____

Time 5:31 PM

Ashley Schwark Ulrich, D.D.S.

Date 11/11/2020

Eaglesoft Medical History Master Updated

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

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?

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	Anaphylaxis	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	High Blood Pressure	◯ 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
Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Bruise Easily	◯ 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	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	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	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:_____

DR. ASHLEY SCHWARK, DDS.

24-Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, the office of Ashley Schwark Ulrich, DDS reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advanced notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing the below, you acknowledge that you have received this notice and understand the policy.

_____ _____

Printed Name Date

_____

Signature

10709 Beardslee Blvd., Suite 101, Bothell WA 98011 | (425-486-8666
thebothelldentists@gmail.com | thebothelldentists.com

DR. ASHLEY SCHWARK, DDS

Consent for Future Local Anesthetic Injections

I, (print name) _____, hereby authorize the dentist and/or hygienist at Dr. Schwark's dental office to perform a local anesthetic injection(s).

I understand, that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur they might include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs it is often temporary, and normal sensation usually returns in several days. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent, may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place. If you have any questions or concerns, we would be happy to answer and explain.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the office as soon as possible.

_____

Patient's Signature | If a Minor, Signature of Parent or Guardian

_____

Dentist/Hygienist/Other Signature

_____

Date

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DR. ASHLEY SCHWARK, DDS

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please Note: It is your right to refuse to sign this acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:_____

_____ _____
Staff Member Signature Date

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