Ernst Schelb, D.M.D.

3355 Cherry Ridge #103 | San Antonio, TX 78230 | (210) 349-1995 | ErnstSchelb.HomeStead.com

Welcome! So that we may provide you with the best possible care, please complete both sides of this information form. All information is completely confidential. Please print clearly.

Who may I thank for referring you? ____ Today's Date: _____/______/______

PATIENT INFORMATION

First Name: _________________________________ Middle Initial: ____ Last Name: _____________________________ Suffix: ____

Physical Address: _______________________________ Apt #: _____City: ___________________State: ____ Zip Code: __________

DOB: _____/______/______ DL #:_______________ Employer Name: ___________________ Title/Occupation: _________________

Cell #:(______)___________ Home #:(______)____________ Work #:(______)_____________ Email: _________________________

SPOUSE INFORMATION

First Name: _________________________________ Middle Initial: ____ Last Name: _____________________________ Suffix: ____

Cell #:(______)___________ Work #:(______)_____________ Employer Name: ________________Title/Occupation: ______________

EMERGENCY CONTACT INFORMATION

First Name: _________________________________ Middle Initial: ____ Last Name: _____________________________ Suffix: ____

Cell #:(______)___________ Home #:(______)____________ Work #:(______)_____________ Relationship: ____________________

RESPONSIBLE PARTY INFOMRATION

First Name: _________________________________ Middle Initial: ____ Last Name: _____________________________ Suffix: ____

Physical Address: _______________________________ Apt #: _____City: ___________________State: ____ Zip Code: __________

Relationship to Patient:________________________ Employer Name: ___________________ Title/Occupation: _________________

Cell #:(______)___________ Home #:(______)____________ Work #:(______)_____________ Email: _________________________

INSURANCE

Company Name #1: _________________________________ Name of Insured: ___________________________________

Member ID: ____ DOB: _____/______/______

Group ID: _______________________ Payer ID: __________ Employer: ____

Company Name #1: _________________________________ Name of Insured: ___________________________________

Member ID: ____ DOB: _____/______/______

Group ID: _______________________ Payer ID: __________ Employer: ____

______ I authorize the release of any information regarding my dental claims.
______ I understand Dr. Schelb is not contracted with my dental insurance but will file claims on my behalf.
______ I authorize and direct payment of the dental insurance otherwise payable to me, to Dr. Schelb.
______ I agree to pay for all charges for dental services not paid by my dental insurance.
______ I agree to pay a 1.5% monthly service fee for any unpaid balance on my account.
______ I will be responsible for any fees related to collection of my unpaid/delinquent account.
______ I understand I may be charged a late cancellation fee without 48 business hours' notice.
______ I have viewed a copy of Dr. Schelb's privacy practices.
______ I give Dr. Schelb and his staff permission to share my dental information with: __________________.
______ I give my permission to mail appointment postcards to me and leave messages for me on my home/cell/work voice mail.
______ I understand Dr. Schelb is a sole practitioner and he is not an associate with any other dentist.

____ _____/______/______

PATIENT SIGNATURE **DATE**

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MEDICAL HISTORY

Today's Date: _____/_____/_____

First Name: ______________________ Middle Initial: _____ Last Name: ______________________ Suffix: _____

Family Physician Name: ______________________ City: _________ State: ______ Phone: (______)____________

Specialist Physician Name: ______________________ City: _________ State: ______ Phone: (______)____________

Current Medication(s)/Drugs/Pills/Dosage (prescription and non-prescription): ______________________

Allergic to Medication/Other: ______________________

Indicate which of the following you have had or currently have. Circle "Yes" or "No" to each item.

Condition			Condition			Condition		
Heart Failure	YES	NO	Drug Addiction	YES	NO	Blood Transfusion	YES	NO
Heart Disease/Attack	YES	NO	Stroke	YES	NO	Hemophilia/Bleeding	YES	NO
Angina Pectoris	YES	NO	Diabetes	YES	NO	Anemia	YES	NO
Heart Disease	YES	NO	Glaucoma	YES	NO	Prolonged Bleeding	YES	NO
Heart Murmur	YES	NO	Thyroid/Glandular	YES	NO	Liver Disease	YES	NO
High Blood Pressure	YES	NO	Chronic Cough	YES	NO	Yellow Jaundice	YES	NO
Low Blood Pressure	YES	NO	Tuberculosis	YES	NO	Encephalitis/West Nile/Zika	YES	NO
Arteriosclerosis	YES	NO	Asthma	YES	NO	Malaria	YES	NO
Mitral Valve Prolapse	YES	NO	Sinus Trouble	YES	NO	MERS/SARS/COVID-19	YES	NO
Artificial Heart Valve	YES	NO	Cancer or Tumor	YES	NO	Meningitis	YES	NO
Heart Pacemaker	YES	NO	Radiation Therapy	YES	NO	Pneumonia	YES	NO
Heart Surgery	YES	NO	Chemotherapy	YES	NO	Pertussis/Tetanus/WhoopCough	YES	NO
Artificial Parts	YES	NO	Hepatitis A (Infection)	YES	NO	Cholera	YES	NO
Rheumatic Fever	YES	NO	Hepatitis B (Serum)	YES	NO	Anthrax	YES	NO
Arthritis/Rheumatism	YES	NO	Hepatitis C, D, or E	YES	NO	Staph/MRSA	YES	NO
Ulcers/stomach	YES	NO	HIV / AIDS	YES	NO	Epilepsy/Seizures	YES	NO
Kidney Condition(s)	YES	NO	Ebola/Marburg	YES	NO	Fainting/Dizzy Spells	YES	NO
Emphysema/COPD	YES	NO	Measles/Mumps/Rubella	YES	NO	Psychiatric Treatment	YES	NO
Asthma/Respiratory	YES	NO	Rabies	YES	NO	Disabled	YES	NO

Have you had or currently have any other disease or condition not listed above?........ **YES NO**

If yes, please list: ______________________

For Women Only: Are you pregnant? **YES NO** Due Date: _____/_____/_____ Are you Nursing? **YES NO**

DENTAL HISTORY

Main Reason for seeking dental care: ______________________

Previous Dentist Name: ______________________ City:___________ State: ______ Phone: (______)____________

Last Dental Visit: _____/_____/_____ Last Cleaning: _____/_____/_____ Last Full Mouth X-Rays: _____/_____/_____

Do your gums bleed or hurt? .... **YES NO**

Does food get caught between your teeth? .... **YES NO**

Do your parents experienced gum disease or tooth loss? .. **YES NO**

Have you noticed any mouth odors or bad tastes?........ **YES NO**

ARE ANY OF YOUR TEETH SENSITIVE TO:

Hot / Cold	YES	NO
Sweets	YES	NO
Biting / Chewing	YES	NO

HAVE YOU EVER HAD:

Any adverse reaction to local anesthesia	YES	NO
Orthodontic treatment	YES	NO
Oral surgery	YES	NO
Periodontal (gum) treatment	YES	NO
Your teeth ground/bite adjustment	YES	NO
Bite plate/Night Guard	YES	NO
Serious Injury to the mouth or head	YES	NO

If yes, please describe: ______________________

DO YOU:

Clench/Grind your teeth	YES	NO
Have tired jaws, especially in the morning	YES	NO
Smoke/Chew tobacco	YES	NO
Regularly chew gum/suck on candy	YES	NO

HAVE YOU EXPERIENCED:

Clicking/Popping of the jaw	YES	NO
Pain (joint, ear, side of face)	YES	NO
Difficulty Opening/Closing mouth	YES	NO
Difficulty chewing	YES	NO
Head/Neck/Shoulder aches	YES	NO
Sore muscles in neck/shoulders	YES	NO
Frequent cold sores/blisters/other oral lesions	YES	NO

Do you wear any type of dental prosthesis, such as dentures, partials or implants? **YES NO** If yes, please list: ______________________

Have you noticed loose teeth or change in your bite? **YES NO** If yes, please describe: ______________________

Are you satisfied with your teeth's appearance? **YES NO** If no, please describe: ______________________

Do you feel nervous about dental treatment? **YES NO** If yes, what is your main concern: ______________________

Have you ever had an upsetting dental experience? **YES NO** If yes, please describe: ______________________

Is there anything else about dental health/history that you would like us to know? **YES NO**

If yes, please describe: ______________________

I understand the above information is necessary to provide me with safe and efficient dental care. I have answered all questions truthfully and to the best of my knowledge. I agree to inform Dr. Schelb of any changes in my medical condition.

______________________ _____/_____/_____

PATIENT SIGNATURE **DATE**