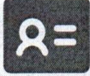
Patient Information



Save some time and upload your **Photo ID or Driver's License** instead.

Let's go →

Basic Information

First Name *

Last Name *

Preferred Name

Date of Birth (MM/DD/YYYY) *

MM/DD/YYYY

Gender *

SSN

Email Address

Mobile Phone *

(___) ___-____

Address

Type in to search your address

Address Line 1 *

Address Line 2

City *

Country *

Zip *

Who is filling out the form today? *

I am the Patient | I am someone else

Responsible Party / Guarantor

Who is financially responsible for the Patients treatment?

The Patient | Someone else

Emergency Contact

Name *

Phone *

(___) ___-____

Relationship

Signature

Draw

Sign here

Release of HIPAA Information

Who can the practice release personal health information to?

You may provide up to 2 contact names:

First Name

Last Name

Phone

First Name

Last Name

Phone

Preferred Pharmacy

Pharmacy Information

Pharmacy Name *

Patient's First Name

Patient's Last Name

What allergies do you have?

Select Allergies

Type or select allergy

Allergies not listed

Please add any allergies you don't see in the list above.

What medical conditions do you have?

Conditions not listed

Please add any problems or conditions that you don't see in the list above.

What medications are you taking?

Select Medications

Type or select medication

Medications not listed

Please add any medications you don't see in the list above.

List any serious illnesses or surgeries

Please add details about any illnesses or surgeries

Has the patient ever been hospitalized?

Yes | No

Do you smoke? Yes | No

Do you drink alcohol? Yes | No

High sugar intake? Yes | No

Are you Pregnant? Yes | No

Are you Nursing? Yes | No

Is the patient under the care of a physician?

Yes | No

Is the patient physically, mentally or emotionally impaired?

Yes | No

Patient's current physical health

Please describe the patients current physical health

Signature *

Draw

Sign here

Date: March 31, 2026 at 11:42 AM

Privacy Policy

Date: March 31, 2026 at 11:20 AM

Dental Practice Financial Policy

The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:
All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.
All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.
Fee estimates for dental care can only be extended for a period of six months from the date of consultation.
Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.
Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

Signature *

Type ▾ Select typeface ▾

Sign here

Date: March 31, 2026 at 11:43 AM

Notice: X-rays and Insurance Coverage

We will recommend that certain x-rays be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.

Signature *

Type ▾ Select typeface ▾

Sign here

Date: March 31, 2026 at 11:43 AM

HIPAA Form

Dr. Tucker Schieck, DDS Dr. Courtney Bollingberg, DDS
I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment. I also authorize payment of insurance benefits to the doctor, unless I have paid my account in full. I am responsible for any fees not covered by insurance, or for any co-payment, at the time services are rendered. I have been offered a copy of this offices HIPAA (Health Insurance Portability and Accountabilities Act) policy to read and/or take with me. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES **YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT**
have read a copy of this office's Notice of Privacy Practices, also known as HIPAA.

Signature *

Type ▾ Select typeface ▾

Sign here