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york dental

1 ABOUT YOU

Today's Date:____/____/____ File #:_____

PATIENT NAME:_____
LAST FIRST MI.

What you prefer to be called:_____ ☐ Male ☐ Female

Birthdate:____/____/____ Age:____ SS#_____

Mailing Address:_____

CITY STATE ZIP

Home Phone#_____

Work Phone#_____ Ext:_____

Cell Phone#_____

Email Address:_____

Referred by:_____

Employer:_____ How Long?:_____

Employer's Address:_____

CITY STATE ZIP

Occupation:_____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name:_____

Do you have any family members that are current patients?

☐ YES ☐ NO Name_____

2 INSURANCE INFO

PRIMARY DENTAL INSURANCE

Co.Name_____

Address:_____

CITY STATE ZIP

Phone #:_____

Insured's SS#:_____

Group# (Plan,Local,or Policy #)_____

Insured's Name:_____

Relation:_____ Date of Birth:___/___/___

Insured's Employer:_____

SECONDARY DENTAL INSURANCE

Co.Name_____

Address:_____

CITY STATE ZIP

Phone #:_____

Insured's SS#:_____

Group# (Plan,Local,or Policy #)_____

Insured's Name:_____

Relation:_____ Date of Birth:___/___/___

Insured's Employer:_____

3 ACCOUNT INFO

Person ultimately responsible for account

Name:_____

Relation:_____

Billing Address:_____

CITY STATE ZIP

SS#:_____

Drivers License#:_____

Work Phone#:_____

Payment method: ☐ Cash ☐ Check

☐ Credit Card-Enter Card #Above (If accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

_____ Initials I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office).

4 IN EVENT OF EMERGENCY

Who should we contact?:_____

Relation:_____

Home Phone #:_____

Work Phone #:_____

Who is your medical Doctor?:_____

M.D.'s Phone #:_____

PLEASE CONTINUE ON BACK

5 DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ No ☐ Yes How Long?_____

Please indicate ☑ any of the following problems:

☐ *Discomfort, clicking or popping in jaw* ☐ *Lost/Broken Filling(s)* ☐ *Stained teeth*

☐ *Red, swollen or bleeding gums* ☐ *Teeth grinding* ☐ *Locking Jaw*

☐ *Sensitive tooth, teeth or gums.* ☐ *Ringing in Ears* ☐ *Bad breath*

☐ *Other:*_____

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't Know

*Previous Dentist:*_____(____)_____
Name Phone #

Last Dental exam: ____/____/____ *Last Dental X - rays:* ____/____/____

*Times per day you brush?*_____ *Times per week you floss?*_____

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

6 MEDICAL HISTORY

Are you taking any of the following medications? ☐ Nerve Pills ☐ Pain Killers (including aspirin)
☐ Muscle relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Others_____

Do you have or ever had any of the following diseases or medical conditions?

Y N Heart Attack / Stroke	**Y N** Kidney Problems	**Y N** Cancer / Tumor	**Y N** Chemotherapy
Y N Heart Surg / Pacemaker	**Y N** Liver Problems	**Y N** Shingles	**Y N** Asthma
Y N Heart Murmur	**Y N** Respiratory Problems	**Y N** Hepatitis	**Y N** Difficulty Breathing
Y N Rheumatic Fever	**Y N** Sinus Problems	**Y N** HIV+AIDS/ARC	**Y N** Diabetes/Hypoglycemia
Y N Mitral Valve Prolapse	**Y N** Stomach Problem/ulcer	**Y N** Arthritis / Rheumatism	**Y N** Leukemia
Y N Artificial Valves	**Y N** Psychiatric Problems	**Y N** Artificial Bones/Joints	**Y N** Anemia
Y N Heart Disease	**Y N** Venereal Diseases	**Y N** Emphysema	**Y N** H/L Blood Pressure
Y N Congenital Heart Defec.	**Y N** Alcohol/Drug Abuse	**Y N** Fainting/Seizures/Epilepsy	**Y N** Bleeding Problems
Y N Chest Pains	**Y N** Tuberculosis TB	**Y N** Frequent Headaches	**Y N** Glaucoma
Y N Scarlet Fever	**Y N** Jaw Problems TMJ/TMD	**Y N** Frequent Neck Pain	**Y N** Back Problems

Please List any other medical condition(s) you have or ever had:_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin
☐ Dental Anesthetics ☐ Others:_____ ***For Women:*** Are you taking Birth Control Pills? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO How Long?:_____ Are you nursing? ☐ YES ☐ NO

- ***We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.***
- ***Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the Office Manager. If account is not paid within 90 days of the date of service you will be reponsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.***
- ***I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. See Financial Policy for details of fees.***
- ***I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it's my responsibility to inform this office of any changes to the information I have provided.***
- ***I have received a copy of the patient financial policy. _____ (Initials)***

Signature:_____ **Date**____/____/____