



# Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

YASICAN-081912-1

## Patient Information

Date \_\_\_\_\_ ID# / SS# \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Drivers License # \_\_\_\_\_ Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone ( \_\_\_\_\_ ) \_\_\_\_\_ or Parents ( \_\_\_\_\_ ) \_\_\_\_\_

Spouse's Name or Parents (if minor) \_\_\_\_\_

Birthdate of Spouse \_\_\_\_\_ SS# \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you ? \_\_\_\_\_

## Health Information

Who is responsible for this account ? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment and examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners . I authorize and request my insurance company to pay directly to the dental or dental group insurance benefits otherwise applicable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payments of all services rendered on my behalf or my dependants.

## Phone Numbers

Home ( \_\_\_\_\_ ) \_\_\_\_\_ Work ( \_\_\_\_\_ ) \_\_\_\_\_ Ext \_\_\_\_\_

Spouse's Work ( \_\_\_\_\_ ) \_\_\_\_\_ Cell ( \_\_\_\_\_ ) \_\_\_\_\_

### In Case of Emergency, Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Dental History**

Reason for today's visit _____	Cigarette, pipe or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blister on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No		How often do you brush? _____

**Health History**

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "len-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (Dexfenfluramine).  Yes  No

Place a mark on "yes" or "no" to indicate if you have and any of the following:

AIDS /HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally with extraction or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck <input type="checkbox"/> Yes <input type="checkbox"/> No
Coughing, persistent or bloody <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, Unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No
Women:	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date _____	Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Medications**

**Allergies**

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_

\_\_\_\_\_

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_