Yorkville Family Dental

New Patient Registration

PATIENT INFORMATION

PATIENT'S NAME: _____

DATE OF BIRTH: _____ S/S #: _____

GENDER: MALE / FEMALE **MARITAL STATUS:** MARRIED / SINGLE / DIVORCED

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE #: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

WORK #: _____

CELL PHONE #: _____

ADDITIONAL PATIENTS

NAME: _____DOB: _____

NAME: _____DOB: _____

NAME: _____DOB: _____

INSURANCE INFORMATION

INS CO: _____PHONE: _____

SUBSCRIBER ID #: _____GROUP #: _____

SUBSCRIBER: _____SUBSCRIBERS DOB : _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

ARE YOU HAVING ANY PROBLEMS WITH YOUR TEETH NOW? _____

_____

DATE OF APPOINTMENT _____TIME_____

Yorkville Family Dental

PATIENT INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____
SOCIAL SECURITY #: _____ GENDER: MALE/ FEMALE
MARITAL STATUS: MARRIED / SINGLE / DIVORCED / OTHER
ADDRESS: _____CITY/STATE/ZIP: _____
HOME PHONE #:_____ OTHER PHONE #:_____ Wk/Cell/Other
EMPLOYER: _____ EMAIL ADDRESS: _____

How did you find out about our office? _____
Is there anything about your smile you'd like to change? _____

Health History Questionnaire

How did you find out about our office? Friend Website Insurance List Ad Other _____

MEDICAL HISTORY

What is the approximate date of your last doctor's visit? Month _____ Year _____

Do you have a physician or family doctor? Yes No

If yes, please list name, address and phone number _____

How do you rate your current physical health? Good Fair Poor

Are you under medical treatment now? Yes No

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No

Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, please list _____

Have you ever taken prescription medication for weight loss (diet pills)? Yes No
If so, did you take any of the following: __Fen-Phen (Fenfluramine-Phentermine) __Redux (Dexfenfluramine)
__Pondimen (Fenfluramine) __Don't remember
__Other _____

Do you have or have you had any of the following?

__High blood pressure	__Joint replacement or Implant	__Hemophilia, abnormal bleeding
__Low blood pressure	__Respiratory problems	__AIDS or HIV
__Heart attack	__Asthma	__Leukemia
__Rheumatic fever	__Hay fever/Allergies	__Emphysema
__Heart disease	__Thyroid problems	__Cancer
__Pacemaker	__Diabetes	__Chemotherapy
__Heart murmur	__Kidney disease	__Radiation therapy
__Mitral valve prolapse	__Liver disease	__Hepatitis/Jaundice
__Angina	__Stomach troubles/Ulcers/Colitis	__Sexually transmitted disease (STD)
__Chest pains	__Fainting/Seizures	__Tuberculosis (TB)
__Stroke	__Epilepsy/Convulsions	__Glaucoma
__Arthritis	__Easily winded	__Other _____
__Swollen ankles	__Frequent headaches	__None of the above

Are you allergic to or have you had any reactions to the following?

__Local anesthetics (e.g. Novocain)	__Sulfa drugs
__Sedatives, dental anesthetics	__Barbiturates
__Penicillin or any other antibiotics	__Iodine
__Aspirin	__Any metals (e.g. nickel, mercury, etc…)
__Erythromycin	__Latex rubber
__Tetracycline	__Other _____
__Codeine	__None of the above

Do you smoke or use tobacco? Yes No
If yes, specify how many packs per day _____

Do you use controlled substances? Yes No

Women only: Please select all that apply to you.
__Pregnant or think you may be pregnant
__Nursing
__Taking oral contraceptives (birth control pills)
__None of the above

If you are pregnant, how many weeks? _____

DENTAL HISTORY

What is the reason for you visit? Check-up Toothache Teeth/Gums Hurting or Bothering Me Other

When was the last time you were seen by a dentist for a complete dental examination and/or teeth cleaning?
Month _____ Year _____

How often do you have dental examinations?
__Twice per year
__Once per year
__Once per 2 years
__Once per 3 years
__More than three years between exams
__This is the first time

How many times a day do you brush your teeth? _____

How many times a day do you floss? _____

What type of toothbrush do you use? Manual Electric Both

Do you have anything listed below?
__Sores or lumps in or near your mouth
__Gums bleed while brushing or flossing
__Food tend to become caught in between teeth
__Clench or grind teeth
__Bite lips or cheeks frequently
__Breathe through mouth while awake or asleep
__Have tired jaws, especially in the morning
__Feel pain to some teeth
__Any other dental problems
__None of the above

Have you ever had any of the following?
__Oral surgery
__Periodontal treatment
__Gum therapy
If yes, please describe
_____
__Your teeth ground or the bite adjusted
__A bite plate or mouth guard
__A serious injury to the mouth or head
__None of the above

Have you ever experienced any of the following?
__Clicking or popping of the jaw
__Pain in joint, ear, side of face
__Difficulty in opening or closing the mouth
__Difficulty in chewing on either side of the mouth
__Headaches, neck aches or shoulder aches
__Sore muscles (neck, shoulders)
__Had difficult tooth extraction in the past
__Had prolonged bleeding following tooth extractions
__None of the above

Are your teeth sensitive to any of the following? Hot/Cold Sweets Biting/Chewing

Do you hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails, etc…)? Yes No

Have you ever had any history of orthodontic treatment (braces, retainer, etc…)? Yes No
If yes, please specify when it was done _____

Do you wear dentures, partials or are you using any other dental devices? Yes No
If yes, please specify what kind and when they were placed _____

Have you ever received oral hygiene instruction regarding the care of your teeth and gums? Yes No

Do you like your smile? Yes No

Are you interested in doing cosmetic treatment?
(For example: teeth whitening, straightening teeth, changing smile) Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

_____

_____

_____

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 doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

__I Agree __I Disagree

Signature_____ Date_____