CONFIDENTIAL

Patient's Last Name First Middle

I Prefer To Be Called

Patient's Street Address

City, State, Zip Code

Birthday Age Sex Race

M S D W

Height Weight Marital Status

Patient's SS# Daytime Phone Number Cellular Number

Driver's License State Number Expiration Date

Closest living relative not living in same household

Their Phone Number

Who referred you to our office

Physician Drs. Phone No.

Current Medications: _____

Person Responsible for Payment Must be 21 or older Relationship to Patient

Mailing Address

City, State, Zip Code

Home Phone Business Phone Cell Phone

SS# Birthdate

Name of Employer Years Employed There

Name of Dental Insurance Contract #

2nd Person Responsible for Payment Relationship Home Phone

Address-Street State Zip Code

Employer Business Phone

SS# Birthdate

Dental Insurance Company Contract #

Last Hospital Admission:

Best Appointment Day

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	NO	YES
ANGINA PECTORIS	❑	❑
MYOCARDIAL INFARCTION	❑	❑
CONGENITAL HEART DEFECT	❑	❑
RHEUMATIC FEVER OR	❑	❑
HEART DISEASE/PACEMAKER	❑	❑
MURMURS	❑	❑
MITRAL VALVE PROLAPSE	❑	❑
HIGH BLOOD PRESSURE	❑	❑
STROKE	❑	❑
TUBERCULOSIS	❑	❑
EMPHYSEMA/ASTHMA	❑	❑
HEADACHES/SINUS	❑	❑
ULCERS	❑	❑
FAINTS/SPELLS	❑	❑
PSYCHIATRIC TREATMENT	❑	❑
TRANSFUSIONS	❑	❑
RECENT EYE SURGERY	❑	❑

	NO	YES
SICKLE CELL TRAIT/DISEASE	❑	❑
BLEEDING PROBLEMS/HEMOPHILIA	❑	❑
HEPATITIS/JAUNDICE	❑	❑
FEVER BLISTERS	❑	❑
DIABETES	❑	❑
THYROID/ADRENAL DISORDERS	❑	❑
STEROID THERAPY	❑	❑
KIDNEY DISEASE/VENEREAL DISEASE	❑	❑
DRUG/ALCOHOL ABUSE	❑	❑
ANTICOAGULANTS/ASPIRIN	❑	❑
LEUKEMIA/CANCER/CHEMOTHERAPY	❑	❑
EPILEPSY CP MD	❑	❑
GLAUCOMA	❑	❑
CONVULSIONS OR SEIZURE DISORDER	❑	❑
AIDS/HIV TESTED	❑	❑
IMPLANTS-HIP OR JOINT SURGERY	❑	❑
OTHER _____	❑	❑

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? WRITE DOWN ANYTHING YOU ARE ALLERGIC TO THAT IS NOT LISTED.

	NO	YES
PENICILLIN	❑	❑
ERYTHROMYCIN	❑	❑
TETRACYCLINE	❑	❑
SULFA	❑	❑
IBUPROFEN/ADVIL/MOTRIN	❑	❑

	NO	YES
ASPIRIN	❑	❑
ACETAMINOPHEN	❑	❑
CODEINE	❑	❑
DENTAL ANESTHETICS	❑	❑
OTHER _____	❑	❑

OVER ⇨

Would you like to know about the dental anxiety relievers available? Yes No

Reason for visit: _____

Do you have problems with your mouth other than the one you are having treated today? _____

Add anything you feel is important to your treatment:

_____

When was your last dental visit? _____

When was your last dental cleaning & exam? _____

Did you experience any problems during your last dental visit? _____

What type of xrays were taken? _____

Was it one where the machine went around your head? Yes No

For patients under age of 18:

1) Name of caregiver? _____

2) Does the caregiver go to Dr. Young for dental care? _____

Home phone _____ Business phone _____ Cell phone _____ Email _____

Parents phone # or where they can be reached. _____

Who will be financially responsible for patient treatment for charges not covered by insurance or medicaid? _____

_____

Are there restrictions on your ability to bring the patient? Yes No If yes, what are they? _____

_____

This information is correct to the best of my knowledge. I hereby consent to the above treatment and payment plan which has been explained to me in full. Furthermore, I understand the possible complications that might occur from the proposed treatment, and authorize any emergency treatment which might be considered necessary for my health.

_____ _____

(DATED) SIGNATURE (Parent or Guardian If Patient is a Minor)

PAYMENT IS DUE WHEN DENTAL SERVICE IS RENDERED

I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me. A 1% monthly finance charge will be added to any unpaid balance.

_____ _____

(DATED) (Signature of Member)