York Dental

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Medical Alert:

Thank you for choosing us for your dental care! Please fill out all sections of this confidential form.
Your information is never shared and kept strictly confidential. If you have any questions or require assistance, please ask!

1. Patient Information

How did you hear about our office? _____

Who may we thank for referring you to our office? _____

Status: ☐ Child ☐Single ☐Married ☐Divorced ☐Widowed **Gender:** ☐ Male ☐ Female

Patient Name: FIRST _____ MI_____ LAST_____

Address _____Apt_____ City _____ State _____ Zip _____

Birthdate: _____ Social Security Number: _____

Home Phone _____ Cell Phone _____

Email _____ Work Phone _____

Employer _____ City _____ Occupation _____

Emergency Contact Person _____ Relation to Patient _____ Phone # _____

PHONE NUMBER where patient/guardian can be reached ***DURING THE DAY*:** ☐ Home ☐ Cell ☐ Work

2. Dental Insurance

Do you have dental insurance coverage? ☐ Yes ☐ No -- ***If no, skip to section 3.***

Primary Insurance Co._____ Phone _____ Address _____

Subscriber Name_____ Subscriber Birthdate _____ Subscriber SSN #: _____

Subscriber ID#_____ Group # _____ Employer/Group Name:_____

Secondary Insurance Co._____ Phone _____ Address _____

Subscriber Name_____ Subscriber Birthdate _____ Subscriber SSN #: _____

Subscriber ID#_____ Group # _____ Employer/Group Name:_____

3. (for Child/Dependent Patient) Responsible Party

Father's Name_____ ☐ Biological ☐ Other _____

Address _____Apt # _____City _____State:_____ Zip_____

Home Phone _____ Work Phone _____Cell Phone _____

Social Security Number _____ Birthdate _____

Employer _____Occupation _____

Mother's Name_____ ☐ Biological ☐ Other _____

Address _____Apt # _____City _____State:_____ Zip_____

Home Phone _____ Work Phone _____Cell Phone _____

Social Security Number _____ Birthdate _____

Employer _____Occupation _____

***** Person financially responsible for this account/ Phone number (if other than parents listed above)***

_____

(Please also complete the back of this form)

Patient First Name: _____ Last Name: _____ DOB_____

4. Personal Medical History (check Yes or No for medical conditions currently or in the past)

AIDS/HIV Positive	□Yes □ No	High Blood Pressure	□Yes □ No	Ulcers	□Yes □ No
Alcoholism	□Yes □ No	Kidney Disease	□Yes □ No	Venereal Disease	□Yes □ No
Anemia	□Yes □ No	Kidney Dialysis	□Yes □ No		
Arthritis	□Yes □ No	Latex Sensitivity	□Yes □ No	**Are you in general**	
Asthma	□Yes □ No	Lupus	□Yes □ No	**good health?**	□Yes □ No
Bone Disease	□Yes □ No	Low Blood Pressure	□Yes □ No		
Chemical Dependency	□Yes □ No	Malignancies	□Yes □ No	**Are you a smoker?**	□Yes □ No
Chest Pain	□Yes □ No	Neck & Back Problems	□Yes □ No		
Circulatory Problems	□Yes □ No	Nervous Problems	□Yes □ No	**Are there any problems**	
Convulsions/Seizures	□Yes □ No	Pacemaker	□Yes □ No	**not listed you would**	
Diabetes	□Yes □ No	Psychiatric Care	□Yes □ No	**like to discuss?**	□Yes □ No
Excessive Bleeding	□Yes □ No	Radiation Treatments	□Yes □ No		
Epilepsy	□Yes □ No	Respiratory Problems	□Yes □ No	_____	
Frequent Headaches	□Yes □ No	Rheumatic Fever	□Yes □ No		
Hearing Impaired	□Yes □ No	Scarlet Fever	□Yes □ No		
Heart Disease	□Yes □ No	Sinus Problems	□Yes □ No	Primary Care Physician's Name	
Heart Valve, Murmur	□Yes □ No	Stroke	□Yes □ No	_____	
Hepatitis/Liver Disease	□Yes □ No	Thyroid Disease	□Yes □ No		
Hepatitis Carrier	□Yes □ No	Tuberculosis	□Yes □ No	City_____	

Organ/Valve/Joint/ Replacement and/or Implant: □Yes □ No If Yes, Type:_____

Doctor: _____ Date: _____

Cancer: □Yes □ No If Yes, Type:_____

Allergies: □ None □ Penicillin □ Latex □ Metals □ Aspirin □ Sulfa □ Other _____

Medications: Any currently being taken? □No □ Yes: Please list all medications or attach list: _____

(Women) Is there a possibility of pregnancy? □ Yes □ No, If Yes, how far along? _____ Due Date:_____

5. Dental History

What is the reason for this visit?_____

How long since your last dental visit? _____ What was done at that time?_____

Previous Dentist _____ City_____Phone_____

How long since your teeth were cleaned at a dental office? _____Were dental x-rays taken? □ Yes □ No

Are your teeth sensitive to: □Hot? □ Cold? □Sweets? □ Pressure? □ No teeth sensitivity

Bleeding of Gums □Yes □ No, If Yes, when? _____

Have you lost any teeth or have any teeth been removed? □ Yes □ No

Have missing teeth been replaced? □ Yes □ No, If Yes, are you unhappy with the replacement? □Yes □No

Do you clench or grind your teeth? □Yes □ No

Jaw Pain, does Jaw click or pop? □Yes □ No

Snoring, Mouth breather □Yes □ No

Prior Orthodontic Treatment □Yes □ No

If Yes, at what age? _____

Have you ever had any problems or complications with previous dental treatment? □ No □ Yes: If yes, please explain:

_____

Are you unhappy with the appearance of your teeth? □Yes □ No If yes, what would you change?

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my or my dependent's medical status. **I authorize the staff to perform the necessary dental services that the patient may need and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company or for legal documentation.**

Signature_____ Date_____ Relationship:□Self □ Parent □Guardian

Reviewed By:_____ Date_____