YORKTOWN FAMILY DENTISTRY, INC.

2001 S. Tiger Drive • Yorktown, IN 47396
Phone: (765) 759-9451 • Fax: (765) 759-8749

PATIENT INFORMATION

(Please print)

Name _____ Age _____ Birthdate _____ Sex _____
Last First (legal name) M.I. Preferred Name

Address _____ City _____ State _____ Zip _____-_____

Home Phone _____ Cell/Pager _____ Work # _____

Social Security Number _____ E-mail Address _____

Is Patient ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Patient's Physician _____ Phone _____ Previous Dentist _____

How did you learn of our office? ☐ Billboard ☐ TV ☐ Newspaper ☐ Radio ☐ Yellow Pages ☐ Website Recommended by _____ ☐ Other _____

Closest Relative (not living in your household) Name _____ Relationship _____

Address _____ Phone _____

Patient's Employer _____ Employer's Address _____

Employer Phone _____ Employee Status: ☐ Hourly ☐ Salaried ☐ Retired ☐ Other _____

How Long Employed? _____ ☐ Full-time Student ☐ Part-time Student Where _____

Dental Insurance Company _____ Effective Date: _____ Group # _____

SPOUSE INFORMATION

Spouse Name _____ Social Security # _____
Last First M.I.

Date of Birth _____

Spouse Employer _____ Employer's Address _____

How Long Employed? _____ Employee Status: ☐ Hourly ☐ Salaried ☐ Retired ☐ Other _____

Dental Insurance Company _____ Effective Date: _____ Group # _____

PERSON RESPONSIBLE FOR PAYMENT

☐ Self ☐ Husband ☐ Wife ☐ Father ☐ Mother ☐ Other _____

Name (if different from patient) _____
Last First M.I.

Home Phone _____ Cell # _____ SS# _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Name of Employer _____ Employer Address _____ Employer Phone _____

Employee Status: ☐ Hourly ☐ Salaried ☐ Retired ☐ Other _____

How Long Employed? _____ Dental Insurance Company _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

MEDICAL HISTORY OF PATIENT

Why are you here today? _____

HAVE YOU EVER HAD: (Check Line)

_____ Anemia
_____ Arthritis
_____ Asthma
_____ Chest Pains
_____ Chronic Cough
_____ Cold Sores
_____ Convulsions
_____ Diabetes
_____ Emphysema
_____ Epilepsy or Seizures
_____ Fainting
_____ Heart Attack
_____ Heart Disease
_____ Heart Murmur
_____ Heart Surgery
_____ Hepatitis
_____ High Blood Pressure
_____ HIV positive/AIDS
_____ Nervous Disorder
_____ Osteoporosis
_____ Pain in Jaw Joints (TMJ)
_____ Rheumatic Fever
_____ Shortness of Breath
_____ Stroke
_____ Swelling of Ankles
_____ Thyroid
_____ Tuberculosis
_____ Venereal Disease

CHECK IF YOU:

_____ are nervous about dental treatment
_____ are you currently taking any supplements/vitamins
_____ have had orthodontic treatment
_____ have ever taken Cortisone
_____ have ever taken anti-coagulants (blood thinners)
_____ have ever taken tranquilizers or sedatives
_____ have ever taken heart medicine or medicine for high blood pressure for any purpose. If so, what _____
_____
_____ are allergic to any food, medicine, or drug. If so, what? _____
_____ have had any post reaction to dental anesthesia
_____ have had prolonged bleeding following any injury or surgery
_____ wear contact lenses
_____ use tobacco Frequency and type:_____
_____ consume alcohol Frequency: ____ per day ____ per week ____ a month
_____ have been under the care of a physician during the past year
_____ have ever had kidney trouble
_____ have ever had major surgery involving heart, pins, joint replacements, etc.
_____ ever had an X-ray treatment for skin disease or tumor
_____ are allergic to metal. If so, what kind? _____

Women: Are you pregnant now? ☐ yes ☐ no Due date: _____
_____ Do you take oral contraceptives?

Please list all current medications:

_____
_____
_____
_____

Please list surgeries and date performed.

_____
_____
_____

IS THERE ANY OTHER CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD KNOW ABOUT?

_____

_____

In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patient's account. I/we agree in event of default in payment, reasonable collection agency fees equal to fifty (50%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on account, plus any applicable court costs.

I, the undersigned, consent to any dental procedure or surgery as deemed necessary, and the giving of such anesthesia as is necessary and proper for such procedure upon myself (son, daughter, ward).

I, the undersigned, do authorize my insurance company to pay benefits directly to Yorktown Family Dentistry, Inc., for services provided either for me or on my behalf by Yorktown Family Dentistry. I also understand that if I have dental insurance coverage, I will be responsible for the portion not covered by my insurance carrier at the time of service, understanding that the office is only able to estimate my cost of treatment and any difference is my responsibility to pay.

I, the undersigned, do authorize Yorktown Family Dentistry to release any information needed to determine these benefits payable for related services.

Signed _____ Relationship _____