

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)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pain in Jaw Joints (TMJ) |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Fainting | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> HIV positive/AIDS | <input type="checkbox"/> Stroke |

CHECK IF YOU:

- | | |
|--|---|
| <input type="checkbox"/> are nervous about dental treatment | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> are you currently taking any supplements/vitamins | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> have had orthodontic treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> have ever taken Cortisone | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> have ever taken anti-coagulants (blood thinners) | |
| <input type="checkbox"/> have ever taken tranquilizers or sedatives | |
| <input type="checkbox"/> 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

Please list all current medications:

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.

Please list surgeries and date performed.

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?

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 _____