York Family Dental
We'll make you smile!

PATIENT INFORMATION

NAME_____ □ MARRIED □ SINGLE □ MINOR □ MALE □ FEMALE
Last First M

BIRTHDATE _____/_____/_____ SS# _____ EMAIL _____

TELEPHONE
Home# Cell# Work#

HOW DO YOU PREFER TO BE CONTACTED TO CONFIRM YOUR APPOINTMENTS? □ TEXT □ PHONE

PLACE OF EMPLOYMENT _____ ADDRESS_____

DENTAL INSURANCE INFORMATION	PERSON TO CONTACT IN CASE OF EMERGENCY
PRIMARY INSURED. IF NO INSURANCE COMPLETE FOR THE RESPONSIBLE PARTY _____ NAME OF INSURANCE PROVIDER _____ SUBSCRIBER NAME DOB _____ SUBSCRIBER # GROUP # _____ SUBSCRIBER SSN# _____ SECONDARY DENTAL INSURANCE	NAME_____ ADDRESS _____ _____ CITY/STATE/ZIP _____ TELEPHONE # _____ RELATIONSHIP _____ Have we seen any other member of your family in our office? _____ Whom may we thank for referring you to our office? _____

AUTHORIZATION

Because we submit the claims for you, a 'Signature on File' must be kept in your record.

AUTHORIZATION TO PAY BENEFITS TO NAMED DENTIST: I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr. Jason Marhue and York Family Dental.

X_____
Patient or Responsible Party Date

York Family Dental
DENTAL HISTORY FORM

Patient Name: _____ DOB ____/____/____

How often do you… Brush your teeth? _____ Floss? _____

When did you have your last… Dental exam? _____ Hygiene visit? _____ X-Ray? _____

Do you… Eat a lot of sweets? Y N Drink coffee with sugar Y N Drink diet or regular soda? Y N Chew gum? Y N

Do you have any dental problems? …… YES NO

If yes, please explain: _____

PERSONAL DENTAL HISTORY

Have you ever had orthodontic treatment? …… YES NO
Have you ever had endodontic treatment? (i.e. root canal) …… YES NO
Have you ever had any teeth removed? …… YES NO
If so, have they been replaced? …… YES NO
Have ever had a fixed bridge, removable partial or complete denture? …… YES NO
Have you had implants? …… YES NO
Have you ever had or been referred for periodontal (gum) treatment or surgery? …… YES NO
Do you have a dry mouth? …… YES NO
Have you ever had a serious injury to the mouth or head? …… YES NO
If so, please describe: _____
Do you play any contact sports? …… YES NO
Do you smoke or use any other tobacco products? …… YES NO

GUM AND BONE

Do you have bad breath or a bad taste in your mouth? …… YES NO
Do you frequently get cold sores, blisters or any lesions? …… YES NO
Do your gums bleed or hurt? …… YES NO

TOOTH STRUCTURE

Are any of your teeth sensitive to hot or cold liquids/foods? …… YES NO
Are any of your teeth sensitive to sweet or sour liquids/foods? …… YES NO
Are any of your teeth sensitive when you bite or place pressure? …… YES NO
Have you noticed any loose teeth or changes in your bite? …… YES NO
Do you notice food or floss getting routinely caught between your teeth? …… YES NO

BITE AND JAW JOINT

Do you clench or grind your teeth (awake or asleep)? …… YES NO
Do you mouth breathe while asleep or awake? …… YES NO
Do you snore? …… YES NO
Have you ever experienced clicking or popping of the jaw? …… YES NO
Have you experienced difficulty opening or closing the mouth? …… YES NO
Do you experience pain (jaw, ear, side of face, headaches)? …… YES NO

DENTAL COMFORT

I gag easily …… YES NO
My teeth are very sensitive …… YES NO
I have difficulty keeping my mouth open for a long period of time …… YES NO
I have health or dental problems I want to discuss during the exam …… YES NO

Any other concerns I would like to talk about:

I CONSENT TO THE DOCTOR'S EXAM AND NECESSARY DIAGNOSTICS, INCLUDING X-RAYS.

PATIENT SIGNATURE _____ DATE _____

York Family Dental
MEDICAL HISTORY FORM

Patient name: _____ Birth Day: _____

Physician's Name: _____ Phone: _____

Physician Address: _____

Is your general health good? YES NO Date of last medical exam: _____

Has there been a change in your health within the last year? ..... YES NO

Explain: _____

Have you been hospitalized of had a serious illness in the last three years? ..... YES NO

Explain: _____

Do you need to be pre-medicated for dental treatment? ..... YES NO

Explain: _____

Do you have, or have you ever been diagnosed with the following:

Heart disease	YES	NO	Hepatitis, other liver disease, jaundice	YES	NO
Heart attack, heart defects	YES	NO	AIDS/HIV positive	YES	NO
Heart murmurs	YES	NO	Tumors/cancer	YES	NO
Rheumatic fever	YES	NO	Arthritis. Rheumatism	YES	NO
Thyroid problems	YES	NO	Any joint replacement	YES	NO
Glaucoma	YES	NO	VD (gonorrhea, syphilis, chlamydia)	YES	NO
Stroke, hardening of arteries	YES	NO	Herpes	YES	NO
High blood pressure	YES	NO	Diabetes	YES	NO
TB, emphysema, other lung disease	YES	NO	Blood disease, anemia, clotting disorder	YES	NO

Have you experienced the following symptoms:

Chest pain (angina)	YES	NO	Swollen ankles	YES	NO
Shortness of breath	YES	NO	Extreme weight loss or gain	YES	NO
Persistent cough, coughing up blood	YES	NO	Bleeding problems, easily bruised	YES	NO
Sinus problems	YES	NO	Difficulty swallowing	YES	NO
Frequent vomiting, nausea	YES	NO	Dry mouth	YES	NO
Dizziness	YES	NO	Ringing in your ears	YES	NO
Headaches	YES	NO	Seizures	YES	NO
Excessive thirst	YES	NO	Frequent urination	YES	NO
Jaundice	YES	NO	Joint pain	YES	NO

Have you experienced any of the following treatments:

Psychiatric care	YES	NO	Radiation treatment	YES	NO
Blood transfusions	YES	NO	Chemotherapy	YES	NO
Major surgery	YES	NO	Pacemaker or prosthetic heart valve	YES	NO

Are you allergic to, or have you reacted adversely to any of the following:

Local anesthetics ("Novocain")	YES	NO	Penicillin or other antibiotics	YES	NO
Sulfa drugs	YES	NO	Barbiturates, sedatives or sleeping pills	YES	NO
Aspirin, Acetaminophen, Ibuprofen	YES	NO	Codeine, Demerol, or other narcotics	YES	NO
Reaction to metals	YES	NO	Latex or rubber dam	YES	NO

Other: _____

Are you taking:

Recreational drugs	YES	NO	Tobacco in any form	YES	NO

Drugs or medicines (including aspirin):

_____

For women only:

Are you or could you be pregnant	YES	NO	Are you trying to get pregnant	YES	NO
Are you nursing	YES	NO	Are you taking oral contraceptives	YES	NO

For all patients:

Do you have, or have you had, any diseases or medical problems not listed on this form? YES NO

Please explain: _____

To the best of my knowledge I have answered each question accurately and completely. I will inform my dentist if there are any changes in my health and/or medication.

Patient signature: _____ Date: _____