WELCOME to Yorktowne Dental Family Practice

PATIENT INFORMATION…

Date _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____ _____ _____
First Name **M.I.** **Last Name**

_____ _____
Nickname **Maiden name**

Sex: ☐ Female ☐ Male **Date of Birth** _____ **Social Security #** _____

eMail _____

Address _____ **Apt#** _____ **City** _____ **State** _____ **Zip Code** _____

Home Tel. _____ **Mobile Tel.** _____

Marital Status: ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated **Employed:** ☐ Full Time ☐ Part Time ☐ Retired ☐ Not

INSURANCE INFORMATION CHANGES…

Has your Insurance changed since your last visit? ☐ Yes ☐ No *(If Yes, please bring your new Insurance ID Card(s) to your appointment.)*

Dental Insurance _____	Employer _____
I.D. # _____	Group # _____

MEDICAL HISTORY UPDATE…

Reason for today's visit _____

Are you in pain? ☐ Yes ☐ No

For how long? _____

	Yes	No
Any changes in your health since your last dental visit? ……	☐	☐
What medications are you taking? _____		
Any changes in medication or dosage including herbal/natural supplements? ……	☐	☐
List changes in medication _____ _____		
Are you taking any medication for bone loss? ……	☐	☐
Have you had a bone mineral density test? ……	☐	☐
If yes, result? _____		
Do you have a persistent sore throat, hoarseness, earache, or feeling of something being caught in your throat? …….	☐	☐
If yes, please provide details _____		
Have you had any surgery or been hospitalized since your last visit? ……	☐	☐
If yes, please provide details _____		

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	Yes	No
Are you currently being treated for any medical problems?	☐	☐
If yes, please provide details _____		
Have you been advised by your physician that you now need to take antibiotics prior to any dental treatment?	☐	☐
Have you been diagnosed with any new allergies since your last visit including, medications, food, metal or latex?	☐	☐
If yes, please provide details _____		
Have you been diagnosed with diabetes?	☐	☐
If yes, ☐ Type 1 ☐ Type 2 ☐ Prediabetic		
Please provide details _____		
Have you been diagnosed with a heart problem?	☐	☐
Have you had knee, hip, or joint replacement or pins placed?	☐	☐
On a scale on 1-10 (10 being the highest) how would you rate your general health?		
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10		
Are you experiencing any jaw aches?	☐	☐
Are you experiencing headaches?	☐	☐
Are you having difficulty sleeping?	☐	☐
How would you rate your smile?	☐	☐
Would you like whiter teeth?	☐	☐
Any other issues or concerns not previously asked on this form?	☐	☐
If yes, please provide details _____		

This section is for women only...

(note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

Is there a possibility of pregnancy?	☐	☐
Expected delivery date _____		
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

I certify that I have read, and I understand the questions above, I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____ X _____

Signature of patient (Parent or Guardian if Minor) *Reviewed by* *Date*