**Patient Information**

We are pleased to welcome you to our office. Please take a few minutes to fill out these forms as completely as you can. If you have any questions we'll be glad to help you.

## PERSONAL

Name_______________________________________________
Last First Middle Initial (Preferred Name)

Gender [ ] M [ ] F Married [ ] Y [ ] N Birth Date________________ SS#_________________
Email__________________________________ Work Phone______________________________
Wireless Phone__________________________ Home Phone______________________________
Preferred contact method [ ] Home Phone [ ] Work Phone [ ] Wireless Phone
Student status if dependent over 19 (for ins.) [ ] Non Student [ ] Full time [ ] Part time
How did you hear about us? __________________________________________________________

## ADDRESS

Check box if same for entire family [ ]
Address_________________________________________________________
Address 2 _______________________________________________________
City_________________________ State_______________ Zip_____________

## INSURANCE POLICY 1

Your relationship to subscriber [ ] Self [ ] Spouse [ ] Child
Subscriber Name___________________________Subscriber ID or SS#_______________________
Insurance Company____________________________ Phone _______________________________
Employer_________________________ Group Name________________ Group #______________
*Please present insurance card to receptionist. Subscriber's Date of Birth _________________

## INSURANCE POLICY 2

Your relationship to subscriber [ ] Self [ ] Spouse [ ] Child
Subscriber Name____________________________Subscriber ID or SS#______________________
Insurance Company____________________________ Phone _______________________________
Employer_________________________ Group Name________________ Group #______________
*Please present insurance card to receptionist. Subscriber's Date of Birth _________________

## AUTHORIZATION

I authorize the release of any dental information necessary to process insurance claims, and the payment of dental benefits to myself or the named provider for professional services rendered.

_____________________________________________ ___________________
Signature of patient, parent or guardian Date

**Medical Information**

Patient Name ____________________________________ Birth Date __________________
First MI Last

List all medications you are now taking or provide a list:

List all medications you are allergic to:

Check any past or present medical conditions:

| | | | |
|---|---|---|---|
| [ ] AIDS | [ ] Excessive Bleeding | [ ] Liver Disease | [ ] Stroke |
| [ ] Allergies_______ | [ ] Fainting | [ ] Mental Disorders | [ ] Tuberculosis |
| ______________ | [ ] Glaucoma | [ ] Nervous Disorders | [ ] Tumors |
| [ ] Anemia | [ ] Growths | [ ] Pacemaker | [ ] Ulcers |
| [ ] Arthritis | [ ] Hay Fever | [ ] **Pregnancy** | [ ] Venereal Disease |
| [ ] Artificial Joints | [ ] Head Injuries | Due Date_____________ | [ ] Codeine Allergy |
| [ ] Asthma | [ ] Heart Disease | [ ] Radiation Treatment | [ ] Penicillin Allergy |
| [ ] Blood Disease | [ ] Heart Murmur | [ ] Respiratory Problems | [ ] Other: |
| [ ] Cancer | [ ] Hepatitis | [ ] Rheumatic Fever | [ ] _______________ |
| [ ] Diabetes | [ ] High Blood Pressure | [ ] Rheumatism | [ ] _______________ |
| [ ] Dizziness | [ ] Jaundice | [ ] Sinus Problems | [ ] _______________ |
| [ ] Epilepsy | [ ] Kidney Disease | [ ] Stomach Problems | [ ] _______________ |

[ ] Yes [ ] No Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please explain: ____________________________________________________________

[ ] Yes [ ] No Are you under the care of a physician? If yes, please explain: _____________________
Name of Physician: __________________________________ Phone: __________________________

[ ] Yes [ ] No Do you have any health problems that need further clarifications? If yes, please explain.
__________________________________________________________________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment.

____________________________________________________________ ___________________
Signature of patient, parent or guardian Date

## Dental Information

Please complete each section as thoroughly as possible. This information is very valuable to the doctor in rendering an accurate and complete diagnosis.

### Gums

[ ] Y [ ] N Have you ever seen a Periodontist? Whom ________________________________________

[ ] Y [ ] N Do your gums bleed or hurt after brushing or flossing?

[ ] Y [ ] N Have you noticed any mouth odors or bad tastes?

[ ] Y [ ] N Have you noticed any loose teeth or feel like there is any tooth movement?

### Jaw Joint & Muscles

[ ] Y [ ] N Have you ever been told you have a TMJ problem?

[ ] Y [ ] N Do you have any clicking, popping or grating sounds in your jaw currently or in the past?

[ ] Y [ ] N Do you have difficulty opening or closing your mouth?

[ ] Y [ ] N Do any muscle on the side of your face get tired with chewing or talking?

### Teeth

[ ] Y [ ] N Are any of your teeth sensitive to cold?

[ ] Y [ ] N Are any of your teeth sensitive to biting sometimes?

[ ] Y [ ] N Does food tend to become caught between your teeth?

[ ] Y [ ] N Do you clench or grind your teeth or has anyone told you that you do?

[ ] Y [ ] N Have you ever had orthodontic work?

[ ] Y [ ] N Has your bite ever been adjusted?

[ ] Y [ ] N Have you noticed any wear?

[ ] Y [ ] N Have you fractured or chipped any of your teeth in the past?

### General

[ ] Y [ ] N Has it been more than 5 years since your last complete set of x-rays?

[ ] Y [ ] N Has it been more that a year since your last complete dental exam?
If yes how many years has it been? ___________________________

[ ] Y [ ] N Has it been more than 6 months since your last cleaning?

[ ] Y [ ] N Do you get frequent headaches?

[ ] Y [ ] N Would you like to keep your teeth all your life?

[ ] Y [ ] N Do you feel nervous about having dental treatment? If yes what is your biggest concern?

_______________________________________________________________________________

[ ] Y [ ] N Have you ever had an upsetting dental experience? If yes please describe.

_______________________________________________________________________________

[ ] Y [ ] N Are you happy with the appearance of your teeth? If no what would you change.

_______________________________________________________________________________

_______________________________________________ ____________________

Signature of patient, parent or guardian Date

## Authorization

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital on any possible complication.

I hereby give Dr. Frank Young the absolute right and permission to use my photographs for educational and diagnostic purposes within the office. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs.

I will pay a fee for broken appointments if I have not given the dental office 24 hours notice.

## Payment Policy

### Patients With Insurance

The staff will be happy to file your insurance forms for you. Please remember that an insurance estimate is only an estimate and not a guarantee of payment. I am expected to pay my estimated portion of the total charge at the conclusion of the initial appointment. If the insurance company does not pay as expected, I will still be responsible for the remaining balance.

### Patients Without Insurance

For treatment with lab work I will pay one half of total cost of treatment at initial appointment and the remaining half at the final appointment. For non lab cases I will pay in full at the time of service.

All balances must be paid in full prior to beginning new treatment. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Payment plans are available upon request.

## Office Hours and Emergency Care

Office hours are 8:00 am to 4:30 pm Monday, Tuesday, Wednesday, and Thursday. Patients with dental emergencies should call the office as early in the day as possible. Please call Dr. Young at 913-709-4023 for emergencies that require immediate attention when the office is not open.

I understand and agree with the terms of this document.

________________________________________ ____________________

Signature of patient, parent or guardian Date