Rittenhouse Dental
Renee Yurovsky, DDS
Cosmetic & Restorative Dentistry

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WELCOME TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birth Date _____ Age _____
Last Name _____ First _____ Initial ___ Home Phone _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Cell Phone _____ Email _____
Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Long Term Partner ❑ Divorced ❑ Widowed ❑ Separated
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE (Person Responsible for Account)

Last Name _____ First _____ Initial _____
Relationship to Pationt _____ Birth Date _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____

ADDITIONAL DENTAL INSURANCE

Insured Last Name _____ First _____ Initial _____
Relationship to Patient _____ Birth Date _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D.# _____ Group # _____

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How often do you floss? _____

Date of Last Dental Visit _____ How often do you brush? _____

Please check all that apply:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Blisters on Lips or Mouth
- ❑ Finger Nail Biting
- ❑ Grinding Teeth
- ❑ Lip or Cheek Biting
- ❑ Loose Teeth or Broken Fillings
- ❑ Orthodontic Treatment
- ❑ Pain Around Ear
- ❑ Periodontal Treatment
- ❑ Sensitivity to Cold
- ❑ Sensitivity to Heat
- ❑ Sensitivity to Sweets
- ❑ Sensitivity When Biting
- ❑ Frequent Headaches
- ❑ Jaw,Head or Neck Injuries
- ❑ Jaw,Difficulty: Clicking and/or Pain
- ❑ Tooth Pain

MEDICAL HISTORY

Physician's name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	❑	❑
2. Have you ever had any serious illnesses or operations?	❑	❑
3. Are you currently taking any medication?	❑	❑
Please describe: _____		
4. Do you smoke?	❑	❑
5. Do you use alcohol, cocaine or other drugs?	❑	❑
6. Do you wear contact lenses?	❑	❑

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	❑	❑
Penicilliin or other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates (sleeping pills)	❑	❑
Sedatives	❑	❑
Lodine	❑	❑
Aspirin	❑	❑
Other	❑	❑
8. (Women Only) Are you: Pregnant?	❑	❑
Nursing?	❑	❑
Taking birth control pills?	❑	❑

Please check all that apply:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Joints/Valves
  List: _____
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally, with extractions or surgery
- ❑ Blood Disease
- ❑ Cancer Type: _____
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Chronic Fatigue Syndrome
- ❑ Circulatory Problems
- ❑ Congenital Heart Lesions
- ❑ Cortisone Treatments
- ❑ Cough: persistant or bloody
- ❑ Diabetes Type: _____
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting or Dizziness
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis Type: _____
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Jaw Pain
- ❑ Latex Sensitivity
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shorthess of Breath
- ❑ Sinus Trouble
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet/Ankles
- ❑ Swollen Neck Glands
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumor or growth on head/neck
- ❑ Ulcer
- ❑ Venereal Disease

ASSIGNMENT AND RELEASE I hereby authorize payment directly to Dr. Renee Yurovsky for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ ***Date*** _____

Print Name _____