

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 Patient _____ 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:

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

MEDICAL HISTORY

Physician's name _____ Date of Last Visit _____

- | | Yes | No | | Yes | No |
|-----------------------------------------------------------|--------------------------|--------------------------|----------------------------------------------------------|--------------------------|--------------------------|
| 1. Are you currently under medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you had any allergic reactions to the following: | | |
| 2. Have you ever had any serious illnesses or operations? | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (eg. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any medication? | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Please describe: _____ | | | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | Barbiturates (sleeping pills) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol, cocaine or other drugs? | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 8. (Women Only) Are you: Pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

Please check all that apply:

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

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 _____