Your Dental

501 5th Ave., Suite 703
New York, NY 10017

Medical Alert for Office Use
Patient #

Thank you for visiting Your Dental. We will do our best to make your visit very pleasant and comfortable!

PATIENT INFORMATION (*Required Information)

*Name _____
LAST FIRST MIDDLE

*Address _____
STREET APT #

_____
CITY STATE ZIP

*Employer _____

& Address _____

*Date of Birth _____ *Social Security # _____

*Sex: **Male / Female** Marital Status: **Single / Married / Other** _____

*Phone: Mobile _____ Work _____ Home _____

May we contact you at work? **Yes** / **No** May we send you information or reminder via e-mail? **Yes** / **No**

E-Mail Address _____ Best time/way to reach you _____

*Emergency: Name _____ Relation to Patient _____ Phone _____

INSURANCE INFORMATION

Primary Dental Carrier

Insurance Co. _____ Group # _____

Plan Name _____

If you are not the subscriber, Subscriber's Name _____

Employer _____

Relation to Patient _____ Social Security # _____ DOB _____

Secondary Dental Carrier, if any. _____

INSURANCE AUTHORIZATION STATEMENT

I hereby authorize the payment of dental insurance benefits directly to Your Dental, P.C. I understand that I am responsible for all the costs of dental treatments. The information on this page is correct to the best of my knowledge.

***Signature** _____ ***Date** _____

If a patient is under 18 years old, Name of a Parent/Legal Guardian _____

Relation to Patient _____ Phone _____

Address _____

OTHER INFORMATION

How did you hear about us? _____ Reason for today's visit _____

Do you have pain or discomfort at this time? **YES** / **NO** *IF YES, describe* _____

Are you under the care of a medical doctor? **YES** / **NO** Doctor's information _____

Last medical checkup _____ Last dental visit _____

Do you smoke or use tobacco products? **YES / NO** *IF YES, how many packs a day?* _____

Do you use alcohol products? **YES / NO** Do you use recreational drugs? **YES / NO**

MEDICAL HISTORY

CONDITIONS

- □ Abnormal Bleeding/Hemophilia
- □ Acid Reflux
- □ Alcohol Abuse/Drug Abuse
- □ Allergies/Hives
- □ Anemia
- □ Angina
- □ Arthritis
- □ Artificial Heart Valve(s)
- □ Asthma
- □ Blood Transfusion
- □ Cancer/Chemotherapy/Radiation Therapy
- □ Congenital Heart Defect(s)
- □ Diabetes (Type I or II)
- □ Difficulty Breathing
- □ Emphysema
- □ Epilepsy
- □ Fainting, Dizzy Spells
- □ Frequent Headaches
- □ Glaucoma
- □ Heart Disease/Attack/Failure
- □ Heart Murmur
- □ Heart Surgery/Pacemaker
- □ Hepatitis/Liver Disease
- □ High/Low Blood Pressure
- □ HIV/AIDS
- □ Joint Replacement(s)
- □ Kidney Problems
- □ Liver Disease
- □ Psychiatric Treatment
- □ Rheumatic Fever
- □ Seizures
- □ Sexually Transmitted Disease
- □ Sickle Cell Disease
- □ Sinus Problems
- □ Stroke
- □ Thyroid Disease
- □ Tuberculosis
- □ Ulcers

Please list any other problems, not listed above: _____

Please list any medications you are currently taking: _____

Blood Pressure Recording _____ Pulse _____ Date _____

ALLERGIES

□ Aspirin □ Codeine □ Dental Anesthetics □ Erythromycin □ Latex □ Metals

□ Penicillin □ Sulfa Drugs □ Tetracycline Other _____

***FOR WOMEN ONLY*, Are you taking birth control pills? YES / NO**

If YES, what is the name of the pills? _____ *For how long?* _____

Are you pregnant? YES / NO *If YES, # of weeks* _____ **Are you nursing? YES / NO**

General Consent For Treatment

To the best of my knowledge, all of the preceding answers are correct. If there is any change in my health or my medicines, I will inform the doctor at the next appointment. I authorize the doctor to perform the necessary dental services that were agreed between the doctor and me. They include any routine procedure(s) or treatment(s) such as oral and physical examination, administration of medication(s), taking X-rays, use of local anesthesia and other non-invasive procedures. I understand that I am responsible for all the costs of dental treatments. To the extent permitted by law, I authorize Your Dental, P.C. to use and disclose my protected health information to conduct health care operations and to carry out payment activities.

_____ _____ _____

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN OF MINOR PATIENT DOCTOR'S SIGNATURE DATE