Welcome! *from* Hilda M. Yacoub, D.D.S.

My staff and I believe that dental care is more than repair. Our intention is to assist you in gaining and maintaining your best dental health.

Your answers to the following questions are the first step in determining your immediate and long-term dental care. Please add any comments you may have… the more we know about your needs and concerns, the better we can serve you. **Thank You!**

1 About You

Today's Date_____

Name_____

I prefer to be called_____ ☐ Male ☐ Female

Birthdate_____ Age_____ SS#_____

Home Address_____

_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home #_____ Cell #_____

Work #_____ Ext_____ DL#_____

Email_____

Employer / Occupation_____

Employer Address_____

Where & when are the best times to reach you?_____

Nearest relative not living with you_____

Phone_____

Whom may we thank for referring you?_____

2 Dental Insurance

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co. Tel#_____

Group # (Plan, Local or Policy #)_____

Insured's Name_____ Relation_____

Insured's Birthdate_____ SS#_____

Insured's Employer_____

Secondary Dental Insurance

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co. Tel#_____

Group # (Plan, Local or Policy #)_____

Insured's Name_____ Relation_____

Insured's Birthdate_____ SS#_____

Insured's Employer_____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

_____

Signature Date

3 Person Responsible for Account

Person Responsible for Account_____

Relationship_____

Billing Address_____

SS#_____ DL#_____

Employer_____ Work #_____

Signature_____

4 Parent / Spouse Information

(If Patient is Under 18 Years)

Name_____

Employer_____

Home #_____ Work #_____

SS#_____ Birthdate_____

DL#_____

5 Dental History

Why have you come to the dentist today?_____

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you or have you ever experienced pain / discomfort in your jaw joint? (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is_____

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had gum disease? ☐ Yes ☐ No

How many times a week do you floss?_____

How many times a day do you brush?_____

Type of bristles ☐ Hard ☐ Medium ☐ Soft

Previous Dentist_____

Address_____

Phone #_____

Last visit date_____

When were the last dental x-rays taken?_____

6 Medical History

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No
Please list each one:_____

Are you taking any dietary supplements (vitamins, etc) ☐ Yes ☐ No
Please list each one:_____

Have you taken any blood thinners in the last 7 days? (i.e., aspirin, coumadin, etc…) ☐ Yes ☐ No

Have you **ever** taken weight loss medications? (i.e., Phen Fen, Redux, etc…) ☐ Yes ☐ No

Have you ever taken Fosamax or any other biphosphonate? (osteoporosis medications) ☐ Yes ☐ No

Are you presently taking any other chemicals or street drugs? ☐ Yes ☐ No

(Death has been known to occur following a dental injection on users of marijuana or cocaine even up to two weeks following the last usage. Don't be a statistic – tell us.)

Please list_____ Last used_____

For women Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No WK#_____
Are you nursing? ☐ Yes ☐ No

Have You Ever Had Any of the Following Diseases or Problems?

Anemia	☐ Yes ☐ No	High / low blood pressure	☐ Yes ☐ No
Arthritis or Rheumatism	☐ Yes ☐ No	HIV / AIDS	☐ Yes ☐ No
Artificial bones, joints, pins, screws or valves	☐ Yes ☐ No	Hospitalized (for any reason)	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Blood clots	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Cancer / Chemotherapy or Radiation	☐ Yes ☐ No	Mitral valve prolapse	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Cardiovascular disease (heart trouble, coronary insufficiency, coronary occlusion, arteriosclerosis, etc.)	☐ Yes ☐ No	Shingles / fever blisters	☐ Yes ☐ No
		Sinus problems or headaches	☐ Yes ☐ No
		Stroke	☐ Yes ☐ No
Chest pain or shortness of breath	☐ Yes ☐ No	Swollen ankles	☐ Yes ☐ No
		Thyroid disease	☐ Yes ☐ No
Damaged or artificial heart valves	☐ Yes ☐ No	Tobacco	☐ Yes ☐ No
Diabetes or Glaucoma	☐ Yes ☐ No	Tuberculosis (TB) or emphysema	☐ Yes ☐ No
Drug / Alcohol abuse	☐ Yes ☐ No	Ulcers or Cholitis	☐ Yes ☐ No
Epilepsy, seizures or fainting spells	☐ Yes ☐ No	Venereal disease	☐ Yes ☐ No
Excessive thirst, urination or dry mouth	☐ Yes ☐ No	Alzheimer's / Dementia	☐ Yes ☐ No
		Depression / Anxiety	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No	Please list any other medical conditions that you have ever had that are not listed above:	
Heart defect, heart murmur or congenital heart lesions	☐ Yes ☐ No		
Hemophilia / abnormal bleeding	☐ Yes ☐ No		
Hepatitis (Type_____)	☐ Yes ☐ No		

7 Medical History

Your current health is ☐ Good ☐ Fair ☐ Poor
Do you have a physician? ☐ Yes ☐ No
Physician's name_____
Phone #_____
Date Last Visit_____

In the event of an emergency, who should we contact?
Their name_____
Relation_____
WK #_____
HM #_____

Are you allergic to any of the following drugs?

Penicillin	☐ Yes ☐ No	Dental Anesthetics	☐ Yes ☐ No
Tetracycline	☐ Yes ☐ No	Erythromycin	☐ Yes ☐ No
Sulfa	☐ Yes ☐ No	Codeine	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Latex (i.e., gloves, etc.)	☐ Yes ☐ No

Please list any other allergies
_____

Have ever had an injury to your (check all that apply)
☐ mouth ☐ chin ☐ teeth ☐ tmj

8 Please Read & Sign

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____
Signature Date

Print Name_____

☐ Parent / Guardian (If under 18 years old)
☐ Power of Attorney

Payment is due in full at time of treatment unless prior arrangements have been approved.

For the Treating Doctor's Use Only

I verbally reviewed the medical / dental information above with the patient named herein. Initials_____ Date_____
Doctor's comments_____

MEDICAL HISTORY UPDATE

1. Date_____ Comments_____ Signature_____
2. Date_____ Comments_____ Signature_____
3. Date_____ Comments_____ Signature_____