

KNIGHT YEAGER DENTISTRY

PATIENT INFORMATION

Last Name _____ First Name _____ Initial _____
Nickname _____ Male _____ Female _____ Birthdate _____ Age _____
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Mailing Address _____ SS# _____
Employer _____ Employer Address _____
Marital Status: _____ Married _____ Single _____ Other _____

PERSON RESPONSIBLE FOR PAYMENT IF NOT YOURSELF

Name _____ Relationship to Patient _____
SS# _____ Telephone Number _____
Employer _____ Work Number _____
Address _____ Home Phone _____
Contact Name, Address & Phone Number _____

Whom may we thank for referring you to our office: _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE:

Name of Insured _____ Date of Birth _____
Relationship to Insured _____ SS# _____
Insurance Company _____ Telephone Number _____
Group Number _____ Policy Number _____

SECONDARY INSURANCE:

Name of Insured _____ Date of Birth _____
Relationship to Insured _____ SS# _____
Insurance Company _____ Telephone Number _____
Group Number _____ Policy Number _____

GENERAL INFORMATION

We are willing to help you receive the maximum benefits your dental program provides. Please provide us with a completed insurance form & card from your insurance company. Your dental benefit program is a contract between you & your employer and the insurance company. This office is not a party to this contract.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR MY ACCOUNT.

Signature _____ Date _____

HEALTH HISTORY

Name: _____

Medical Physician: _____

Are you under medical care at this time? No Yes Explain _____

Have you ever been diagnosed with any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Endocrine Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> AIDS | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Angina | <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Bisphosphanate |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Therapy(Fosamax,
Boniva, Zometa) |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Hypertension | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | |

Do you have any allergies to medication? _____

List any serious illnesses _____

Have you ever had hives or a rash? _____

Do you tend to bleed a long time? _____

Have you had heart trouble? _____

Have you ever had chest pains? _____

Have you ever been exposed to the HIV virus? _____

Do you have a blood disorder? _____

Have you ever had convulsions or seizures? _____

Do you have artificial joints? _____

Do you smoke? _____ How much? _____

Do you drink alcohol? _____ How much? _____

Do you have any medical problems not mentioned? _____

(Women) Are you pregnant at this time? _____ How long? _____

Please list any drugs and the dosage you are taking presently

What are your dental concerns? _____

- | | | | | |
|--|---|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Tooth shifting | <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Recession | <input type="checkbox"/> Night grinding | <input type="checkbox"/> Swelling | <input type="checkbox"/> Mouth odors | |

Comments: _____

As the above information changes it is my responsibility to notify this office.

Patient Signature: _____ Date _____ *Thank you!*

Date _____ Update _____ Initials _____
