HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you ever had an unusual reaction due to dental treatment? ◯ Yes ◯ No Explain _____

Are you under a physician's care now? ◯ Yes ◯ No Explain _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No Explain _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No Explain _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No Explain _____

_____

Are you on a special diet? ◯ Yes ◯ No Explain _____

Do you use controlled substances? ◯ Yes ◯ No Explain _____

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Do you have, or have you had, any of the following? *Condition may require medication

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pacemaker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

_____

FOR CHILDREN ONLY

	YES	NO
Is this the child's first trip to the dentist?	☐	☐
Is your child taking fluoride supplements?	☐	☐
Does someone other than the child brush his/her teeth for him/her?	☐	☐

If yes, how frequently? _____

Please list child's special interests or hobbies. _____

Please list any pets and their names. _____

Please list any brothers or sisters and ages. _____

Is there any additional information about your child which will allow us to better care for your child? _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

W. TRENT YADON, D.D.S.

The below information is important to our providing optimal care for you and will be held in confidence.

Date _____

Patient's Name _____ S.S. # ____-____-____ Birthday ____/____/____

If patient is a minor, give parent's or guardian's name _____

Patient's Address _____ City _____ Zip _____

Home Telephone Number _____ Work Number _____ Cell Phone _____

Responsible Party Name _____ Responsible Party Address _____

Patient's Employer and Address _____

Spouse's Name _____ Spouse's Employer _____

Name of nearest relative not living with you _____

Complete Address _____ Phone Number _____

PAYMENT POLICY

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.

If other arrangements need to be made, please discuss this with the receptionist prior to treatment.

INSURANCE

We are happy to file your insurance. Please bring your forms to the desk.

Policy Holder's Name _____ Policy Holder's Birthdate _____

Policy Holder's Social Security Number _____ Group Number _____

I hereby authorize Dr. Trent Yadon to release to my insurance company information acquired in the course of my dental care.
I hereby authorize benefits to be paid directly to Dr. Trent Yadon. I understand I am responsible for any unpaid balance.

_____ _____

Signature of Patient/Insured Date

DENTAL / MEDICAL HISTORY

Why are you seeking dental care? _____

How long since your last visit,

and what treatment was rendered? _____

When were your teeth last cleaned? _____

How long do you expect to keep your natural teeth? _____

How often do you brush? _____

How often do you floss? _____

	YES	NO
Has the fear of discomfort kept you from regular dental visits?	☐	☐
If you could sleep through your dental visit, would you be interested?	☐	☐
Are you happy with the appearance of your smile?	☐	☐
What would you like changed? _____		
Do your gums bleed easily?	☐	☐
Are your teeth sensitive to hot, cold, or sweets?	☐	☐
Do you frequently drink soda pop?	☐	☐
Do your jaws click or pop when you open & close?	☐	☐
Do you use tobacco?	☐	☐

Cigarettes - Packs per day? _____ Smokeless Tobacco - How frequent? _____

Whom may we thank for referring you? _____

- OVER -