

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

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

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?	<input type="checkbox"/>	<input type="checkbox"/>
If you could sleep through your dental visit, would you be interested?	<input type="checkbox"/>	<input type="checkbox"/>
Are you happy with the appearance of your smile?	<input type="checkbox"/>	<input type="checkbox"/>
What would you like changed? _____		
Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot, cold, or sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently drink soda pop?	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws click or pop when you open & close?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Cigarettes - Packs per day? _____ Smokeless Tobacco - How frequent? _____		

Whom may we thank for referring you? _____