WELCOME to Westgate Family Dental!

ABOUT YOU

Today's Date_____

Name _____

Address _____

City_____ State_____ Zip_____

E-mail_____

Sex M ☐ F ☐

Birthdate:___/___/___ Age:

SS#_____ DL#_____

Single ☐ Married ☐ Divorced ☐ Widowed ☐

Separated ☐ Partnered for____years Minor ☐

Employer/School:_____

Occupation_____

Employer's Address:_____

Spouse's Name_____

Employer_____

Birthdate____/____/_____

Do we have permission to text/email/call to confirm your dental appointments?_____

Whom may we Thank for referring you?_____

Who is the Responsible Party?_____

DENTAL INSURANCE

Subscriber's Name?_____

Insurance Co. _____

Group# _____

Is the patient covered by additional insurance?

Yes ☐ No ☐

Subscriber's Name_____

Birthdate:___/___/___ Age: _____ SS#_____

Relationship to Patient_____

Insurance Co_____

Group#_____

Assignment And Release

I certify that I, and/or my dependent(s), have insurance coverage with_____and assign directly to **Dr. Yarbrough** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____Date_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please Print name of Patient, Parent, Guardian/Personal Representative

Phone Numbers

Home (___)_____ Work(___)_____ Ext___ Mobile(___)_____

Spouse's Work (___)_____ Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specifiy someone who does not live in your household.)

Name_____ Relationship_____

Home Phone (___)_____ Work Phone(___)_____ Mobile(___)_____

Dental History

Reason for today's visit_____

_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Date of last x-rays_____

Circle "yes" or "no" to indicate if you have had any of the following:

Bad Breath	Yes	No	Burning sensation on tongue	Yes	No
Bleeding Gums	Yes	No	Chew on one side of mouth	Yes	No
Blisters on lips/mouth	Yes	No	Cigarette - tobacco use	Yes	No
			Clicking or popping jaw	Yes	No
			Dry mouth	Yes	No
			Fingernail biting	Yes	No
			Foreign objects	Yes	No
			Grinding teeth	Yes	No
			Gums swollen or tender	Yes	No
			Jaw pain or tiredness	Yes	No
			Lip or cheek biting	Yes	No
			Loose teeth or broken fillings	Yes	No

Mouth Breather	Yes	No
Mouth pain, brushing	Yes	No
Orthodontic treatment	Yes	No
Pain around ear	Yes	No
Periodontal treatment	Yes	No
Sensitivity to cold	Yes	No
Sensitivity to hot	Yes	No
Sensitivity to sweets	Yes	No
Sensitive to biting	Yes	No
Sores or growths in mouth	Yes	No

How often do you floss?_____

How often do you brush?_____

Medical History

Physician's Name_____Date of Last Visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Circle "yes" or "no" to indicate if you have had any of the following

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Radiation Treatment	Yes	No
Anemia	Yes	No	Fainting or dizziness	Yes	No	Respiratory Disease	Yes	No
Arthritis, Rheumatism	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Artificial Heart Valve	Yes	No	Headaches	Yes	No	Scarlet Fever	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Shortness of Breath	Yes	No
Asthma	Yes	No	Heart Problems	Yes	No	Sinus Trouble	Yes	No
Back Problems	Yes	No	Hepatitis Type_____	Yes	No	Skin Rash	Yes	No
Bleeding Abnormally	Yes	No	Herpes	Yes	No	Special Diet	Yes	No
Blood Disease	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Jaundice	Yes	No	Swollen Feet or Ankles	Yes	No
What type?_____ When?_____			Jaw Pain	Yes	No	Swollen Neck Glands	Yes	No
Chemical Dependency	Yes	No	Kidney Disease	Yes	No	Thyroid Problems	Yes	No
Circulatory Problems	Yes	No	Liver Disease	Yes	No	Tonsillitis	Yes	No
Congenital Heart Lesions	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Cortisone Treatments	Yes	No	Mitral Valve Prolapse	Yes	No	Tumors/Growth	Yes	No
Cough, Persistent or bloody	Yes	No	Nervous Problems	Yes	No	Ulcer	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No	Venereal Disease	Yes	No
Emphysema	Yes	No	Psychiatric Care	Yes	No	Weight Loss (unexpected)	Yes	No
Wear Contact Lenses?	Yes	No	**Women:**					
Do you take Blood Thinners?	Yes	No	Are you pregnant?	Yes	No	Due Date_____		
			Are you nursing?	Yes	No	Taking Birth Control Pills?	Yes	No

Surgeries?_____When?_____

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name_____

Phone (___)_____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____

_____

Doctor Notes_____

_____

_____

Updates (to be filled in at a future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions?_____

Are you taking any new medicatons?_____If so, what?_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____