

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 (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (____) _____ Work Phone(____) _____ Mobile(____) _____

Dental History

Reason for today's visit _____	Burning sensation on tongue	Yes	No	Mouth Breather	Yes	No
_____	Chew on one side of mouth	Yes	No	Mouth pain, brushing	Yes	No
Former Dentist _____	Cigarette - tobacco use	Yes	No	Orthodontic treatment	Yes	No
City/State _____	Clicking or popping jaw	Yes	No	Pain around ear	Yes	No
Date of last dental visit _____	Dry mouth	Yes	No	Periodontal treatment	Yes	No
Date of last x-rays _____	Fingernail biting	Yes	No	Sensitivity to cold	Yes	No
Circle "yes" or "no" to indicate if you have had any of the following:	Foreign objects	Yes	No	Sensitivity to hot	Yes	No
Bad Breath	Grinding teeth	Yes	No	Sensitivity to sweets	Yes	No
Bleeding Gums	Gums swollen or tender	Yes	No	Sensitive to biting	Yes	No
Blisters on lips/mouth	Jaw pain or tiredness	Yes	No	Sores or growths in mouth	Yes	No
	Lip or cheek biting	Yes	No	How often do you floss? _____		
	Loose teeth or broken fillings	Yes	No	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	Veneral 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

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

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 _____