WELCOME

In order to for us to provide you with the best possible care, please fill out this form completely in ink.

ALL INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE.

Name_____ Birthdate_____

Address_____ City_____ State_____ Zip_____

Social security number_____ Email_____

Home phone_____ Business phone_____ Cell phone_____

Check one: O minor O single O married O divorced O widowed O separated

Employer _____

Business address_____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone_____

Medical History

Physician_____ Office phone_____Date of last exam_____

Please circle answer

1. Do you have frequent headaches . . . . . yes no
2. Do you think you may snore, or has anyone told you that you snore . . . . yes no
3. Are you currently under medical treatment. . . . . yes no
4. Have you ever been hospitalized for any reason within the past 5 years . . yes no

If yes, please explain _____

5. Are you taking any medications . . . . . yes no

If yes, please list_____

6. Do you use tobacco . . . . . yes no
7. Do you use controlled substances. . . . . yes no If yes, please list_____
8. Are you wearing contact lenses . . . . . yes no
9. Are you allergic to or have you had any reaction to the following:
   - Local anesthetics (e.g. Novocaine) . . . . . yes no
   - Penicillin or other antibiotics . . . . . yes no
   - Sulfa drugs . . . . . yes no
   - Aspirin . . . . . yes no
   - Any metals (nickel, mercury, etc). . . . . yes no
   - Latex . . . . . yes no
   - Other (please list) . . . . . yes no
10. Do you have a persistent cough (lasting more than 2 weeks) not associated with a known illness . . . . . yes no
11. To the best of your knowledge, do you have or have you had any of the following:

- High blood pressure . . . . . yes no
- Low blood pressure . . . . . yes no
- Heart attack . . . . . yes no
- Rheumatic fever . . . . . yes no
- Swollen ankles . . . . . yes no
- Fainting . . . . . yes no
- Seizures/ epilepsy/ convulsions . . yes no
- Asthma . . . . . yes no
- Leukemia . . . . . yes no
- Diabetes . . . . . yes no

- Lung/ respiratory disease . . . . . yes no
- Kidney disease . . . . . yes no
- AIDS or HIV infection . . . . . yes no
- Thyroid problem . . . . . yes no
- Heart problems . . . . . yes no
- Cardiac pacemaker . . . . . yes no
- Cyanotic heart disease . . . . . yes no
- Bacterial endocarditis . . . . . yes no
- Heart valve replacement . . . . . yes no
- Chest pains . . . . . yes no
- Angina . . . . . yes no
- Anemia . . . . . yes no
- Liver disease/ hepatitis . . . . . yes no
- Cancer . . . . . yes no
- Arthritis . . . . . yes no
- Joint replacement . . . . . yes no
- Sexually transmitted disease . . . yes no
- Stomach problems/ ulcers . . . . yes no
- Hayfever/ seasonal allergies . . . yes no
- Tuberculosis . . . . . yes no
- Radiation treatment . . . . . yes no
- Glaucoma . . . . . yes no

- Other or additional conditions you feel we should be aware of . . . . . .

12. Women only:
    - Are you pregnant or think you may be pregnant . . . . . yes no
    - Are you nursing . . . . . yes no
    - Are you taking oral contraceptives . . . . . yes no

Dental History

1. Do your gums bleed while brushing or flossing . . . . . yes no
2. Do you have any teeth pain . . . . . yes no
3. Do you have any sores/ lumps in or near your mouth . . . . . yes no
4. Have you had any head, neck, or jaw injuries . . . . . yes no
5. Do you have or have you had any jaw problems such as
    - clicking . . . . . yes no
    - pain (jaw or ear or face pain) . . . . . yes no
    - difficulty in opening or closing . . . . . yes no
6. Do you clench or grind your teeth . . . . . yes no
7. Have you ever had difficult extractions in the past . . . . . yes no
8. Have you ever had prolonged bleeding after extractions . . . . yes no
9. Have you had orthodontic treatment . . . . . yes no
10. Do you like the way your teeth/ smile look . . . . . yes no

Any additional information you would like to add:

_____

Authorization and Release

I certify that I have read and understand the above, and to the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment of all services rendered on my behalf or my dependents. To the extent permissible by law, I consent to your use and disclosure of my protected information to carry out payment activities in connection with my (or my dependents) treatment.

_____/ date_____

Signature of patient (or guardian)

Dr Henry T Young 415 - 73rd Street Brooklyn, NY 11209 718-238-7878
General and Cosmetic Dentistry
Orofacial Pain and Temporomandibular Disorders
Diplomate American Board of Orofacial Pain
Fellow American Academy of Orofacial Pain
Fellow Academy of General Dentistry

We would like to welcome you to our office. To avoid confusion and misunderstandings, we would like to inform you of our office payment policy.

Payment for services rendered is due at the time of treatment. We accept cash, Mastercard/Visa, and money orders. We do not accept personal checks for the first visit.

We do not accept insurance as payment. We are not a participating dentist in any insurance plans. We do however, as a courtesy for our patients, fill out the insurance forms and submit them for payment to the patient. In other words, the patient will pay us at the time of service, and their insurance will reimburse them directly for covered services.

Please note that we do not participate with Medicaid, Medicare, nor No-fault insurance. You will not be able to submit claims for services performed.

Please arrive on time for your appointment so that we can spend the appropriate amount of time with you, without rushing through the treatment. We try very hard to stay on schedule so our patients do not have to wait. However, please understand that occasionally procedures take longer than anticipated, and there may be a short wait.

If you will be arriving by car, you should be aware that parking in this area can be difficult at times, and extra time is usually needed to find parking.

Please fill out the enclosed medical history and bring it with you for your appointment. Do not leave any answers blank; write “N/A” if not applicable, or “not sure” if you do not know the answer.

Again, welcome to our office; we look forward to meeting you and providing you with our service. If at any time you have any questions, please feel free to call us.

Your appointment is for _____

This time is reserved exclusively for you. 24 hours notice is required if you are unable to keep your appointment.