Yorktown Dental Group, LLP

yorktowndentalgroup.org
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Welcome to our Practice

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ Last ____________ First ____ MI ____________ Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ____________ **Best time to call:** ____________

Phone: ________ Home ________ Mobile ________ Work ____ Ext ________ Fax ________ Other

Address: ____________ Address 1 ____________ Address 2

____________ City ____ State _____-____ Zip Code

If Student, Name, City, State of School/College

____

____

Whom may we thank for referring you to our practice?

____

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact:

____

____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ____________ **Phone:** ____________

Employer Address: ____________ Address 1 ____________ Address 2

____________ City ____ State _____-____ Zip Code

Responsible Party Information:

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______ (Last) ______ (First) ___ (MI) ______ (Preferred Name)

Title: ______ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______ **SS#:** ___-__-____ **DL#:** ______

Email Address: ______ **Best time to call:** ______

Phone: ______ (Home) ______ (Mobile) ______ (Work) ______ (Ext) ______ (Fax) ______ (Other)

Address: ______ (Address 1) ______ (Address 2)

______ (City) ______ (State) _____-____ (Zip Code)

Primary Dental Insurance:

Name of Insured: ______ (Last) ______ (First) ___ (MI)

Insured's Birth Date: ______ **ID #:** ______ **Group #:** ______

Insured's Address: ______ (Address 1) ______ (Address 2)

______ (City) ______ (State) _____-____ (Zip Code)

Insured's Employer Name: ______

Employer Address: ______ (Address 1) ______ (Address 2)

______ (City) ______ (State) _____-____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______

Insurance Address: ______ (Address 1) ______ (Address 2)

______ (City) ______ (State) _____-____ (Zip Code)

Insurance Company Phone Number:

______

______

Secondary Dental Insurance:

Name of Insured: ______ (Last) ______ (First) ___ (MI)

Insured's Birth Date: ______ **ID #:** ______ **Group #:** ______

Insured's Address: ______ (Address 1) ______ (Address 2)

City State Zip Code

Insured's Employer Name: ____________________

Employer Address: ____________________ ____________________

Address 1 Address 2

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____________________

Insurance Address: ____________________ ____________________

Address 1 Address 2

City State Zip Code

Insurance Company Phone Number:

Do you have any additional insurance? * ◯ Yes ◯ No

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern?

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

- [ ] Had complications from past dental treatment?
- [ ] Had trouble getting numb?
- [ ] Had any reactions to local anesthetic?
- [ ] Had/have braces, orthodontic treatment?
- [ ] You experience dry mouth?
- [ ] Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth?
- [ ] Food gets trapped between any teeth?
- [ ] Have you ever whitened or bleached your teeth?
- [ ] You have difficulty chewing?
- [ ] You clench or grind your teeth?
- [ ] You wear or have worn a bite appliance?
- [ ] Gums bleed when brushing or flossing?
- [ ] Treated for gum disease or were told you have lost bone around your teeth?
- [ ] Noticed an unpleasant taste or odor in your mouth?
- [ ] Experienced gum recession?
- [ ] Had any teeth become loose on their own (without injury)?
- [ ] Experienced a burning sensation in your mouth?
- [ ] You snore or wake up frequently during the night?
- [ ] Erupting teeth very early or very late?
- [ ] Primary (baby) teeth removed that were not loose?
- [ ] Permanent or extra (supernumeray) teeth removed?
- [ ] Supernumerary (extra) or congenitally missing teeth?
- [ ] Chipped or injured priamry or permanent teeth?
- [ ] Any lost or broken fillings?
- [ ] Jaw fractures, cysts, infections?
- [ ] Any teeth treated with root canals or pulpotomies?
- [ ] Frequent canker sores or cold sores?
- [ ] History of speach problems or speach therapy?
- [ ] Difficulty breathing through nose?
- [ ] Mouth breathing habit or snoring at night?
- [ ] Frequent oral habits (sucking finger,chewing pen,ect)?
- [ ] Teeth causing irritation to lip, cheek or gums?
- [ ] Any broken or missing fillings?

- [ ] Have you experienced popping and/or clicking of your jaw joint?
- [ ] Have you been treated for "TMJ" or "TMD" problems?
- [ ] Soreness in jaw muscles or face muscles?

If any of the checked boxes need further explanation, please describe:

____

____

____

____

Consent for Services and Financial Policy

Thank you for choosing Yorktown Dental Group. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. Payment is expected at the time of service unless other arrangements have been made before the start of treatment. Payment Option: -NO INTEREST Payment Plans(2) from CareCredit . Allow you to pay over time with NO INTEREST(1) . Convenient, low monthly payment plans(2) also

available . No annual fees or pre-payment penalties For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment(3). Payment for any co-payments or deductibles is expected when treatment is performed. Please be aware that not all insurance carriers allow assignment of benefits to our office. If this is your situation; payment is expected at the time your claims are submitted to your insurance company. A fee of $26 is charged for any patients who miss or cancel an appointment, without 24 hour notice. Yorktown Dental Group charged $26 for returned checks. Unpaid accounts that are forwarded to our collection service will be charged a $35 service fee. If you choose to discontinue care before treatment is completed, a refund will be determined upon a review of your case. Patients are responsible for any fees incurred, i.e. lab fees once treatment has started. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient:

____

____

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

Signature ______________________________ **Date** __________

Response Date: __________

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Medical History

Patient Name: ______________________ ______________________ ____ ______________________
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ acne	☐ ADHD	☐ AIDS	☐ Allergy Anesthetic
☐ Allergy Flouride	☐ Allergy Latex	☐ Allergy Metal	☐ Allergy Nickel
☐ Allergy Penicillin	☐ Allergy Sulfa Drugs	☐ Alzheimer's/Dementia	☐ Anemia
☐ Aneurysm	☐ Angina	☐ Anti-anflamatory	☐ Anxiety
☐ Arrhythmia	☐ Arteriosclerosis	☐ Arthritis	☐ Artificial Joints
☐ Asperger	☐ Asthma	☐ bells palsy	☐ Birth Defects
☐ blood clot in lung	☐ Blood Disease	☐ Blood Disorder	☐ Blood pressure- high
☐ Blood pressure- low	☐ Bone Disorder	☐ Bone Marrow Transpla	☐ Cancer
☐ Chemotherapy	☐ Chest Pains	☐ Clotting Disorder	☐ Depression
☐ Diabetes	☐ Dizziness	☐ Ear Infections	☐ Eating disorder
☐ Emphysema	☐ Endocarditis	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting	☐ Frequent Colds	☐ fulvestrant	☐ Glaucoma
☐ Head Injuries	☐ Hearing problems	☐ Heart Attack	☐ Heart Disease
☐ heart failure	☐ Heart Murmur	☐ Hepatitis	☐ Herpes
☐ High Cholesterol	☐ HIV Positive	☐ Hypertension	☐ Immune System Issue
☐ Injury to Face/Head	☐ Injury to Neck	☐ Jaundice	☐ Joint problems
☐ Joint Replacement	☐ Kidney Disease	☐ Liver Disease	☐ lung transplant
☐ Lupis	☐ Major Injury	☐ Melanoma in lung	☐ Mental Health Dis
☐ Migrains/Headaches	☐ Mitral valve pro	☐ Mouth Breather	☐ MS
☐ Nervous Disorders	☐ Pacemaker	☐ Parkinson's Disease	☐ Polio, mononucleosis
☐ Postural Vertigo	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Seizures	☐ Shortness of breath	☐ Sinus Problems	☐ Skin Disorder
☐ Sleep Apnea	☐ Speech problems	☐ STD- Any	☐ Stroke
☐ Swollen Ankles/Feet	☐ Swollen Neck Glands	☐ Throat Infections	☐ Thyroid Problem
☐ TMJ	☐ Tonsil/Adenoid Cond	☐ tourettes	☐ Tuberculosis
☐ Tumors	☐ Ulcers		

Please explain/clarify any conditions or alerts selected above and those not listed, and list any other Allergy or Medications you are currently taking:

Conditions/Alerts:

____

____

____

____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med:

____

____

Are you under medical treatment now? * ◯ Yes ◯ No

If Yes, please provide appropriate information below:

Name of your Physician and Phone Number:

____

____

Name of your Cardiologist and Phone Number

____

____

Name of your Oncologist and Phone Number

____

____

Preferred Pharmacy and Phone Number:

____

____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

____

____

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Signature ______________________________ **Date** __________

Response Date: __________