YBD
YOUR BRONX DENTIST

Patient's Name:_____ Preferred Name:_____ Birth Date:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Address:_____ City:_____ State:_____ Zip_____

If minor, parents' names:_____

Marital Status_____ Name of Spouse:_____

Whom may we thank for referring you to our office?_____

BILLING, CREDIT & INSURANCE INFORMATION: ☐ Not covered by dental insurance

Your social security#:_____ Dental Insurance Co:_____ Group#_____

Covered by spouse's insurance ☐ yes ☐ no

Spouse's dental insurance co:_____ Group#_____

Spouse's birthday_____ Social Security#_____

Medical Health History

Do you have or have you had any of the following?
(Please check any that apply)

☐ Cancer or Tumor
☐ Heart ailment, angina, murmur, MVP, heart defect
☐ Rheumatic fever or rheumatic heart disease
☐ Artificial joint or valve
☐ High or low blood pressure
☐ Pacemaker
☐ Tuberculosis or other lung problems
☐ Kidney disease
☐ Alcoholism
☐ Blood transfusion
☐ Diabetes
☐ Neurological condition, epilepsy, seizures or fainting
☐ Emotional condition
☐ Arthritis
☐ Herpes or cold sores
☐ AIDS or HIV positive
☐ Migraine headaches or frequent headaches
☐ Anemia or blood disorders
☐ Hay fever, sinus trouble, allergies or hives
☐ Asthma
☐ Abnormal bleeding after extractions, surgery or trauma

Do you smoke or use chewing tobacco ☐ yes ☐ no

Are you allergic to, or have you reacted adversely to any of the following:
☐ Latex materials
☐ Penicillin or other antibiotics
☐ Local Anesthetics ("Novocain")
☐ Codeine or other narcotics
☐ Sulfa Drugs
☐ Barbiturates, sedatives or sleeping pills
☐ Aspirin
☐ Other: _____

Are you taking any of the following:
☐ Aspirin
☐ Anticoagulants (blood thinners)
☐ Antibiotics or Sulfa Drugs
☐ High Blood Pressure Medicine
☐ Antidepressants or tranquilizers
☐ Insulin, Orinase or other diabetes drugs
☐ Nitroglycerin
☐ Cortisone or other steroids
☐ Osteoporosis (bone density) medication
☐ Other:_____

Women:
☐ May be pregnant
Expected delivery date:_____
☐ Taking hormones or contraception

Dental History

Are you happy with the appearance of your smile? ☐ yes ☐ no
If not, please explain _____

Are you wearing removable dental appliances? ☐ yes ☐ no

How long has it been since your last dental hygiene appointment? _____

Do you have lumps or sores in your mouth now? ☐ yes ☐ no

Have you ever been treated for gum or periodontal disease ☐ yes ☐ no
If so when? _____ How was it treated? _____

Do hot and cold beverages cause discomfort or pain in your mouth? ☐ yes ☐ no

Do your gums bleed? ☐ yes ☐ no
If so, when? _____

Do you clench or grind your teeth? ☐ yes ☐ no

Do you wear a nightguard or bite plate? ☐ yes ☐ no

Are you nervous about dental treatment? ☐ yes ☐ no

Have you ever had an unpleasant experience in the dental office? ☐ yes ☐ no

What are your primary dental concerns now? ☐ yes ☐ no

Are you interested in whitening your teeth? ☐ yes ☐ no

Do you use an electric toothbrush? ☐ yes ☐ no

Do you have chronic bad breath? ☐ yes ☐ no

Do you get fever blisters or canker sores? ☐ yes ☐ no

Please list all medications you are taking: _____

_____

Physician's Name: _____ Phone # _____

Do you have any disease or condition not listed above? _____

Please add anything else you would like us to know _____

_____

The above information is accurate and complete to the best of my knowledge. My medical history was reviewed during my examination, and I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

In accordance with HIPAA, I authorize Your Bronx Dentist P.C. to provide my insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

I give Your Bronx Dentist P.C. permission to contact me or leave messages: ☐ **on my cell phone** ☐ **at my home** ☐ **at my place of business** ☐ **by email**

I give Your Bronx Dentist P.C. permission to discuss my treatment with: _____

Relationship _____

Date: _____ Signature: _____

Date: _____ Dentist Signature: _____