DR. GREGORY YOUNT
MATTOON DENTAL

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc.Sec.#_____

Last First Initial

Address_____

City_____ State_____ Zip_____ Home Phone_____

Cell Phone_____ Email_____

Sex ☐M ☐F Age_____ Birthday mm/dd/yyyy _____ ☐Single ☐Married ☐Widowed ☐Separated

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Business Email_____

Whom may we thank for referring you? _____

Notify in case of emergency_____ Home Phone_____

Cell Phone_____ Business Phone_____

Email_____

Primary Insurance

Person Responsible for Account_____

Relation to Patient_____ Birthday_____ Soc.Sec.#_____

Address (if different from patient)_____ Home Phone_____

City_____ State_____ Zip Code_____

Cell Phone_____ Email_____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Business Email_____

Insurance Company_____ Phone_____

Insurance Email_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan_____

Additional Insurance

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name_____ Relation to Patient_____ Birthday_____

Address (if different from patient)_____ Soc.Sec#_____

City_____ State_____ Zip_____ Home Phone_____

Cell Phone_____ Email_____

Subscriber Employed by_____ Business Phone_____

Business Email_____

Insurance Company_____ Phone _____ ext._____

Insurance Email_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan_____

Dental History

What would you like us to do today?_____ Are you in Dental discomfort today?_____

Former Dentist_____ Address_____

Dentist's Email_____ Phone_____

Date of last dental care_____ Date of last X-Rays_____

Check (☒) yes or no if you have had problems with any of the following: (please fill out completely)

☐Y ☐N AIDS/HIV Positive	☐Y ☐N Food collection between teeth	☐Y ☐N Periodontal Treatment	☐Y ☐N Sensitivity to sweets
☐Y ☐N Bleeding gums	☐Y ☐N Grinding or clenching teeth	☐Y ☐N Sensitivity to cold	☐Y ☐N sensitivity when biting
☐Y ☐N clicking or popping jaw	☐Y ☐N Loose teeth or broken fillings	☐Y ☐N Sensitivity to hot	☐Y ☐N Sores or growths in mouth

How often do you brush?_____ Floss?_____

How do you feel about the appearance of your teeth?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Other information about your dental health or previous treatment_____

_____

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Medical History

Physician's Name_____ Phone_____

Date of last visit_____ Have you had any serious illnesses or operations? ☐Y ☐N

If yes, please describe_____

Are you currently under physician care? ☐Y ☐N If yes, describe_____

Have you ever had a blood transfusion? ☐Y ☐N If yes, give dates_____

Have you ever taken Fen-Phen/Redux? ☐Y ☐N

Women: Are you Pregnant: ☐Y ☐N Nursing? ☐Y ☐N Taking birth control? ☐Y ☐N

Check (☐) Yes or No whether you have had any of the following: (please fill out completely)

☐Y ☐N AIDS/HIV Positive	☐Y ☐N Cough, Persistent	☐Y ☐N Jaw pain	☐Y ☐N Shingles
☐Y ☐N Anaphylaxis	☐Y ☐N Cough up Blood	☐Y ☐N Kidney disease	☐Y ☐N Shortness of breath
☐Y ☐N Anemia	☐Y ☐N Diabetes	☐Y ☐N Liver Disease	☐Y ☐N Skin rash
☐Y ☐N Arthritis, Rheumatism	☐Y ☐N Epilepsy	☐Y ☐N Material Allergies	☐Y ☐N Spina Bifida
☐Y ☐N Artificial Heart Valves	☐Y ☐N Fainting	☐Y ☐N Mitral valve prolapse	☐Y ☐N Stroke
☐Y ☐N Artificial Joints	☐Y ☐N Food allergies	☐Y ☐N Nervous problems	☐Y ☐N Surgical implant
☐Y ☐N Asthma	☐Y ☐N Glaucoma	☐Y ☐N Pacemaker/Heart Surgery	☐Y ☐N Swelling of feet / ankles
☐Y ☐N Atopic (allergy prone)	☐Y ☐N Headaches	☐Y ☐N Psychiatric Care	☐Y ☐N Thyroid Disease
☐Y ☐N Back problems	☐Y ☐N Heart murmur	☐Y ☐N Rapid Weight gain or loss	☐Y ☐N Tobacco Habit
☐Y ☐N Blood disease	☐Y ☐N Heart Problems*	☐Y ☐N Radiation Treatment	☐Y ☐N Tonsillitis
☐Y ☐N Cancer*	☐Y ☐N Hemophilia / Bleeding	☐Y ☐N Respiratory disease	☐Y ☐N Tuberculosis
☐Y ☐N Chemical dependency	☐Y ☐N Herpes	☐Y ☐N Rheumatic / Scarlet fever	☐Y ☐N Ulcer / Colitis
☐Y ☐N Chemotherapy	☐Y ☐N Hepatitis	☐Y ☐N Venereal disease	☐Y ☐N Circulatory problems
☐Y ☐N Cortisone Treatments	☐Y ☐N High Blood Pressure		

Is patient currently taking any medications? Does patient have drug allergies? If yes, please list all:

_____

Authorization

I have reviewd the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered.

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.

Signature_____ Date_____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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