Dr. Kenneth Yorgey, DMD PC - NEW PATIENT WELCOME FORM

804-932-5396 *3215 Rock Creek Villa Drive, Suite F Quinton VA 23141*

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 will be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ SSN _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Home # _____ Cell # _____ Email _____

Sex Male/Female Age _____ Birthdate _____ ___Single ___Married ___Widowed ___Separated ___Divorced

Patient Employed by _____ _____ Occupation _____

Business Address _____

Business # _____ Business Email _____

Whom may we thank for referring you? _____

Emergency Contact _____ Home # _____

Cell # _____ Business # _____ Email _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ SSN _____

Address (if different from patient) _____ City _____

State _____ Zip _____ Home # _____ Cell # _____

Person Responsible Employed By _____ Occupation_____

Business Address _____

Business # _____ Business Email _____

Insurance Company _____ Phone # _____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name(s) of other dependent(s) under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes/No Subscribers Name _____

Relationship to patient _____ Birthdate _____ SSN _____

Address (if different from patient) _____ City _____

State _____ Zip _____ Home # _____ Cell # _____

Subscriber Employed By _____ Occupation_____

Business Address _____

Business # _____ Business Email _____

Insurance Company _____ Phone # _____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name(s) of other dependent(s) under this plan _____

Please complete the next section.

DENTAL HISTORY

What would you like us to do today? _____

Former Dentist _____ Address _____ Phone # _____

Dentist's Email_____ Date of last dental care _____ Date of last X-rays _____

Please circle Yes or No for the following.

Bad Breath - Yes/No	Grinding or clenching teeth - Yes/No	Sensitivity to hot - Yes/No
Bleeding Gums - Yes/No	Loose teeth/broken fillings - Yes/No	Sensitivity to sweets - Yes/No
Clicking or popping jaw - Yes/No	Periodontal treatment - Yes/No	Sensitivity when biting - Yes/No
Food collection between teeth - Yes/No	Sensitivity to cold - Yes/No	Sores or growths in mouth - Yes/No

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? Yes/No

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician _____ Phone # _____Date of last visit _____

Have you had any serious illnesses or operations? Yes/No If yes, please describe _____

Are you currently under physician care? Yes/No If yes, please describe _____

Have you ever had a blood transfusion? Yes/ No If yes, please give approximate dates _____

Have you ever taken Fen-Phen/Redux? Yes/No

Women: Are you pregnant? - Yes/No Nursing - Yes/No Taking birth control pills? - Yes/No

Please check, if you have had any of the following (check all that apply):

___AIDS/HIV Positive
___Anaphylaxis
___Anemia
___Arthritis, Rheumatism
___Artificial heart valves
___Artificial joints
___Asthma
___Atopic (allergy prone)
___Back problems
___Blood disease
___Cancer
___Chemical Dependency
___Chemotherapy
___Circulatory problems
___Cortisone treatments
___Cough, persistent
___ Cough up blood
___Diabetes
___Epilepsy
___Fainting
___Food Allergies
___Glaucoma
___Headaches
___Heart murmur
___Heart Problems
Describe _____
___Hemophilia/Abnormal bleeding
___Herpes
___Hepatitis
___High blood pressure
___Jaw pain
___Kidney disease/malfunction
___Liver disease
___Material allergies (latex) wool, metal, chemicals)
___Mitral valve prolapse
___Nervous problems
___Pacemaker/Heart surgery
___Psychiatric care
___Rapid weight gain/loss
___Radiation treatment
___Respiratory disease
___Rheumatic/Scarlet fever
___Shingles
___Shortness of breath
___Skin rash
___Spina Bifida
___Stroke
___Surgical Implant
___Swelling of feet/ ankles
___Thyroid disease/ malfunction
___Tobacco habit
___Tonsillitis
___Tuberculosis
___Ulcer/Colitis
___Venereal disease
___Other
Describe_____
_____
_____
_____

List medications you are taking, if any_____ List drug allergies, if any _____

_____ _____

AUTHORIZATION

I have reviewed 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 the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this 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.

Signature _____ Date _____

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