YSDC Patient Information

Patient Name: _____ Date: _____
Last First
Mother/Legal Guardian _____ DOB _____ Father / Legal Guardian _____ DOB _____

Birth Date: _____ Age: _____ ☐ Male ☐ Female How Did You Hear About This Office?: _____

Phone (Home): _____ (Cell): _____ Email: _____

Address: _____
Street Apartment #

_____ _____ _____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

DOES THE PATIENT HAVE ANY HEALTH ISSUES AT THIS TIME? ☐ Yes ☐ No

Please check those that apply:

- ☐ ADHD
- ☐ AIDS/HIV
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism
- ☐ Birth Defects
- ☐ Cancer
- ☐ Clotting Disorder
- ☐ Diabetes
- ☐ Disabilities/Special Needs
- ☐ Epilepsy
- ☐ Fainting
- ☐ G6 PD
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Trouble
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Sickle Cell
- ☐ Sickle Cell Trait
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Use of Diet Aids
- ☐ Anesthesia Allergy
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Allergies
- ☐ Speech/Hearing Problems

- If you answered "Yes" to any of the above, please explain:
  _____
- Does the patient have any other health problems? ☐ Yes ☐ No
  If yes, please explain: _____
- Has the patient had surgery? ☐ Yes ☐ No
  If yes, please explain: _____
- Is the patient taking any medications at this time? ☐ Yes ☐ No
  If yes, please explain: _____
- Is the patient allergic to any medications? ☐ Yes ☐ No If yes, What? _____
- Does the patient have any dental problems/concerns at this time? ☐ Yes ☐ No
  If yes, please explain: _____
- Nearest Relative: _____ Telephone: _____ Relationship: _____
- Please list Other Siblings Seen Here: _____
- Patient's Pediatrician: _____ Telephone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Consent for Services

As a condition of your treatment by this office financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature: _____ Printed Name: _____ Date: _____ Relationship to Patient: _____