THOMAS J. YANIK, D.D.S.

2 CONCORDE WAY, BLDG. 1 • WINDSOR LOCKS, CT 06096
(860) 623-1116

We are pleased to welcome you to Dr. Yanik's office. 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.

PATIENT INFORMATION

Date _____

Patient's name_____(_____)
Last First Middle Initial Preferred Name

Residence_____
Street City Zip

Mailing Address _____
Street City Zip

Home phone _____ Cell # _____ Work # _____

Email Address_____

Birthdate _____ Marital Status: Single __ Married __ Widowed __ Separated __ Divorced __

Employer _____

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

PERSON RESPONSIBLE FOR ACCOUNT

Name_____
Last First Middle

Residence_____
Street City Zip

Mailing Address _____
Street City Zip

Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

Social Security # _____ Birthdate _____ Relationship to Patient_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ ID#_____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes ___ No __ If yes

Insured's Name_____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ ID#_____

Insurance Co. Address _____ Phone No. _____

DENTAL HISTORY

Reason for today's visit? _____

Former Dentist _____ Address _____

Date of last dental care _____ For what reason? _____

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Tooth Sensitivity
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Cold sores or mouth ulcers

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

If so, explain:

MEDICAL HISTORY

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illness or operations? ❑ Y ❑ N

If yes, describe:

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Heart disease or surgery
❑ Y ❑ N Artificial heart valve
❑ Y ❑ N Pacemaker
❑ Y ❑ N Heart murmur
❑ Y ❑ N High Blood Pressure
❑ Y ❑ N Stroke
❑ Y ❑ N AIDS / HIV positive
❑ Y ❑ N Anemia or blood disease
❑ Y ❑ N Hepatitis or liver disease
❑ Y ❑ N Kidney disease
❑ Y ❑ N Diabetes
❑ Y ❑ N Thyroid disease
❑ Y ❑ N Cancer
❑ Y ❑ N Epilepsy
❑ Y ❑ N Anxiety
❑ Y ❑ N Depression
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Material allergies (latex, metal, jewelry)
❑ Y ❑ N Asthma
❑ Y ❑ N Sinus trouble
❑ Y ❑ N Arthritis
❑ Y ❑ N Ulcers or Colitis
❑ Y ❑ N Glaucoma
❑ Y ❑ N Artificial prosthetic joint
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Other:

Is patient currently taking medication? If yes, list all:

_____
_____
_____
_____
_____

Does patient have drug allergies?

Penicillin? Aspirin? Codeine? Other?

_____
_____
_____
_____

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. 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.