YAVNER DENTAL ASSOCIATES
101 Main Street Suite 220, Medford MA 02155
781-396-2179 – yavnerdental@gmail.com

Welcome – Thank you for selecting our Dental Healthcare Team. We will strive to provide you with the best possible Dental Care. To help us meet all your Dental Healthcare needs, please fill out this form. If you have any questions or need assistance, please ask us.

Patient Information

Name: _____ Birthdate: _____ SS#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Current Address: _____

Email Address: _____

Circle Appropriate Item: Minor Single Married Divorced/Widowed Separated

Employer: _____ Spouse or Parent's Name: _____

Person to contact in case of emergency: _____ Phone: _____

Whom may we thank for referring you: _____

Responsible Party

Name of person responsible for this account: _____ Relationship to Patient: _____

Insurance Information

Do you have dental insurance? Yes No

If yes:

Name of Insurance: _____

Subscriber Name: _____

Subscriber SS#: _____

Subscriber date of birth: _____

Employer: _____

Group #: _____

Patient ID #: _____

Office Use Only

Type 1 _____

Type 2 _____

Type 3 _____

Deductible _____

Category _____

Maximum _____

Do you have secondary or additional dental insurance? Yes No

If yes:

Name of Insurance: _____

Subscriber Name: _____

Subscriber SS#: _____

Subscriber date of birth: _____

Employer: _____

Group #: _____

Patient ID #: _____

Patient Medical History

Physician: _____ City: _____ Date of last exam: _____

Are you under medical treatment now? Yes No

Have you been hospitalized for any serious illness or surgical treatment in the last 5 years? Yes No

If yes, please explain: _____

Are you taking any medications (including non-prescription)? Yes No

If yes, what medications: _____

Do you use tobacco? Yes NoDo you use controlled substances? Yes No Do you wear contact lenses? Yes No

Are you allergic to or have had reactions to any of the following?

Latex rubber Local anesthetics (e.g. Novocain) Penicillin/Antibiotics Sulfa drugs Metals

Others: _____

Do you have or have you had any of the following?

AIDS/HIV	Yes No	Cortisone/steroids	Yes No	Liver disease	Yes No
Anemia	Yes No	Diabetes	Yes No	Low blood pressure	Yes No
Angina	Yes No	Emphysema/COPD	Yes No	Osteoporosis	Yes No
Arthritis/Gout	Yes No	Fainting spells	Yes No	Parathyroid disease	Yes No
Artificial heart valve	Yes No	Glaucoma	Yes No	Recent weight loss	Yes No
Artificial joint	Yes No	Heart attack/failure	Yes No	Sickle cell disease	Yes No
Asthma	Yes No	Heart arrhythmia	Yes No	Seizures	Yes No
Blood disease	Yes No	Heart pacemaker	Yes No	Stroke	Yes No
Breathing problems	Yes No	Hepatitis	Yes No	Swelling of legs	Yes No
Bruise easily	Yes No	High blood pressure	Yes No	Thyroid disease	Yes No
Cancer	Yes No	High cholesterol	Yes No	Tuberculosis	Yes No
Chemotherapy	Yes No	Kidney problems	Yes No	Ulcers	Yes No

Have you had any other serious illness? Yes No If yes: _____

Women only: Is there any chance you are pregnant? Yes No

Patient Dental History

Name and location of previous dentist: _____ Date of last exam: _____

Do your gums bleed while brushing or flossing?	Yes No	Do you have frequent headaches?	Yes No
Are your teeth sensitive to hot/cold food/drink?	Yes No	Do you clench/grind your teeth?	Yes No
Are your teeth sensitive to sweet/sour food/drink?	Yes No	Do you bite your lips/cheeks often?	Yes No
Have you had a head/neck/jaw injury?	Yes No	Have you had past difficult extractions?	Yes No
Do you have sores/lumps in/near your mouth?	Yes No	Have you ever had clicking in your jaw?	Yes No
Have you had prolonged bleeding after extraction?	Yes No	Have you had orthodontic treatment?	Yes No
Have you had pain in your jaw?	Yes No	Do you wear dentures or partials?	Yes No
Have you ever had difficulty chewing?	Yes No	Have you had oral hygiene instruction?	Yes No
Have you had difficulty opening/closing your jaw?	Yes No	Do you like your smile?	Yes No

Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to the third party payers and/or health practitioners. I authorize and request my insurance to pay directly to the dentist or dental groups insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

Signature of patient (parent/guardian if minor): _____

_____ I have read and the understand the HIPPA (i.e. privacy) policies for this office.

_____ I authorize Yavner Dental Associates to call, text, email, or leave voicemail messages.

Signature: _____ Date: _____