TERESA K. YANG, D.D.S., INC.

PATIENT INFORMATION

All information provided will be kept strictly CONFIDENTIAL.

Patient'sName_____Age_____Birthday_____ ☐Male ☐Female
LAST FIRST

Residence Address_____

City _____State _____Zip Code_____

Driver's License No._____Social Security No._____Res Phone( )_____

Employed by_____ Occupation_____

Business Address_____Bus Phone( )_____

Cell Phone( )_____Email address_____

In case of emergency, contact _____Relationship_____

Phone( )_____Whom may we thank for referring you?_____

FINANCIAL INFORMATION

Person responsible for acct_____Relationship_____

Address_____Phone( )_____

Insurance Company (primary)_____Phone( )_____

Name of insured_____Birthdate_____Social security no_____

Relationship_____Group no_____Policy no_____

Insurance Company (secondary)_____Phone( )_____

Name of insured_____Birthdate_____Social security no_____

Relationship_____Group no_____Policy no_____

TERMS AND CONDITIONS

I understand that payment is expected at the time dental services are rendered.
If I carry insurance, the office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, I will be responsible for any amounts not covered by my insurance company.
ASSIGNMENT OF INSURANCE: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.
Should my account be sent to collections due to non-payment, I will be responsible for all collections charges.
I further understand that any estimates given are subject to change based on the changing conditions in my mouth.
I have read the above conditions of treatment and agree.

Signed_____Date_____

CONSENT FOR TREATMENT

I hereby grant Dr. Yang authority to perform routine dental procedures, such as but not limited to x-rays, cleanings, fillings, crowns, as may be deemed necessary or advisable in my diagnosis and treatment. I also grant authority for the doctor to administer anesthetics, antibiotics, analgesics, or nitrous oxide sedation as may be deemed necessary in the course of treatment. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed_____Date_____

PLEASE COMPLETE **OTHER SIDE**

HEALTH QUESTIONNAIRE

MEDICAL HISTORY

1. Are you currently under the care of a physician? ☐ Yes ☐ No For what condition?_____
2. Name of physician_____Date of last physical_____

   Address_____Phone( )_____
3. Are you taking any medications? ☐ Yes ☐ No What medications?_____

   _____
4. Are you allergic to any drugs, medications, or latex? ☐ Yes ☐ No What?_____
5. Do you use any recreational drugs? ☐ Yes ☐ No What?_____
6. Do you take/have you taken medications to increase bone density? ☐ Yes ☐ No What?_____
7. Do you have any heart condition (heart attack, heart murmur, mitro valve prolapse, high blood pressure)? ☐ Yes ☐No

   Describe:_____
8. (Women) Are you pregnant? ☐ Yes ☐ No
9. Do you have or have you had any of the following:

Diabetes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No	Joint Replacement ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No	AIDS/HIV positive ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Organ transplant ☐ Yes ☐ No	Epilepsy or seizures ☐ Yes ☐ No
Serious asthma ☐ Yes ☐ No		

_____

_____

DENTAL HISTORY

1. Reason for this dental visit_____
2. Have you had any serious problems with previous dental treatment? ☐ Yes ☐ No Explain:_____

   _____
3. Are you satisfied with the appearance and/or color of your teeth? ☐ Yes ☐ No Explain:_____

   _____
4. Are any of your teeth sensitive? ☐ Yes ☐ No Explain:_____

   _____
5. Does dental treatment make you nervous? ☐ Yes ☐ No Explain:_____

   _____

MEDICAL HISTORY UPDATE
Date_____ _____

_____

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MEDICAL HISTORY UPDATE
Date_____ _____

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