MARSHALL B. YOUNG, D.D.S
FAMILY AND COSMETIC DENTISTRY

Date ___________________

Patient Information

Patient Name ____ Sex M F Date of Birth ____/_____/______ Age _____

Social Security _______-______-_________ Cell Phone ( ) _______ - _____________ Alternate Telephone ( ) _______ - _____________

Address ____ City __________________________ State ____ Zip ________

Email ____

Married Single Divorced Widowed Partnered

Patient Employer ____ Occupation____

Whom may we thank for referring you? ____

Dental Insurance

Dental Insurance Company __________________________________ Group # _________________

Subscriber's Name ____ Relationship to Patient _________________

Subscriber's Date of Birth ______/_______/_________ Subscriber's ID # or SSN __________________________

Additional Dental Insurance Company__________________________________ Group # _________________

Subscriber's Name ____ Relationship to Patient _________________

Subscriber's Date of Birth ______/_______/_________ Subscriber's ID # or SSN __________________________

ASSIGNMENT AND RELEASE

I certify that I, ________________________________ and/or my dependent(s), have insurance coverage with ____________________________ and assign directly to Dr. Marshall B. Young all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Marshall B. Young may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ ____ ____/_____/______

Signature of Patient, Parent, Guardian, or Personal Representative (Please print name) Today's Date

Emergency Contact

Name ____ Relationship _________________ Telephone ( ) _______ - ____________

Dental History

Reason for Today's Visit ____

Former Dentist / City / State ____ Date of last visit __________________________

Please mark a "yes" or "no" if you CURRENTLY have any of the following:

Bad Breath	y	n	Grinding or Clenching teeth	y	n	Loose teeth or broken fillings	y	n
Bleeding Gums	y	n	Clicking, Popping, or Locking jaw	y	n	Chewing on one side of mouth	y	n
Gums swollen, or tender	y	n	Jaw Pain or tiredness	y	n	Sensitivity to cold	y	n
Food trapping between teeth	y	n	Pain around ear	y	n	Sensitivity to hot	y	n
Lip or cheek biting habit	y	n	Fingernail Biting or other habits	y	n	Sensitivity to bite/pressure	y	n
Blisters on lips or mouth	y	n	History of Orthodontic Treatment	y	n	Mouth Breathing, Snoring	y	n
Burning Sensation on Tongue	y	n	History of Wisdom Teeth Extraction	y	n	How often do you brush __________________		
Lumps, Swellings, growths	y	n	History of Periodontal treatment	y	n	How often do you floss __________________		
Dry Mouth	y	n	Tobacco Products of any kind	y	n	Toothbrush type	Electric	Manual

Medical History

Physician's Name ____ Date of last visit ____________

Have you ever used a bisphosphonate medication?.. y n
(Common brand names are: Fosamax, Actonel, Didronel, Boniva)

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"?.. y n
[Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine)]

Please mark a "yes" or "no" if you have had any of the following:

Condition			Condition			Condition		
AIDS/HIV	y	n	Gastrointestinal Problems	y	n	Scarlet Fever	y	n
Anemia	y	n	Glaucoma	y	n	Sinus Trouble	y	n
Arthritis, Rheumatism	y	n	Headaches	y	n	Skin Rash	y	n
Artificial Joints/Replacement	y	n	Heart Murmur/ Heart Problems	y	n	Special Diet	y	n
Location ____________			Hepatitis	y	n	Stroke	y	n
Premedication needed?	y	n	Type________________			Swollen Feet or Ankles	y	n
Artificial Heart Valves	y	n	Herpes	y	n	Swollen Neck Glands	y	n
Asthma	y	n	Type________________			Thyroid Problems	y	n
Back/Neck Problems	y	n	High Blood Pressure	y	n	Tonsillitis	y	n
Bleeding abnormally	y	n	High Cholesterol	y	n	Tuberculosis	y	n
Blood Disease	y	n	Kidney Problems	y	n	Tumor or Growth	y	n
Cancer	y	n	Liver Problems	y	n	Location ____________		
Type______________			Low Blood Pressure	y	n			
Chemotherapy	y	n	Mitral Valve Prolapse	y	n			
Chemical Dependency	y	n	Multiple Sclerosis	y	n			
Circulatory Problems	y	n	Nervous Problems	y	n	*Women*:		
Congenital Heart Defects	y	n	Neurological Issues	y	n	Are you pregnant?	y	n
Cough - Persistent or bloody	y	n	Pacemaker	y	n	Due Date ____/_____/_______		
Diabetes	y	n	Psychiatric Care	y	n	Are you nursing?	y	n
Emphysema	y	n	Radiation Treatment	y	n	Birth control pills?	y	n
Epilepsy	y	n	Respiratory Issue	y	n			
Fainting or dizziness	y	n	Rheumatic Fever	y	n			

Any other conditions not mentioned above? ____

Medications

List any medications you are currently taking and the correlating diagnosis:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Allergies

Aspirin Barbiturates Codeine Iodine Latex Local Anesthetic Penicillin Sulfa

Other, Please Specify: ____

Patient Signature

_____ (initials) I agree that the statements made above are true and correct to the best of my knowledge.
_____ (initials) I have reviewed and understand the Notice of Privacy Practices.

____________________________ ____________________________ ____/_____/______
Signature of Patient, Parent, Guardian, or Personal Representative (Please print name) Today's Date