YAHNKE DENTAL

Health Sheet

Name: _____ Nickname: _____ D.O.B.: _____

Who should we contact in case of an emergency?_____

Home Phone: _____ Cell Phone: _____ Relationship: _____

We care about your overall health. Please fill out the entire questionnaire as many medical conditions and medications may be linked to your dental care. Thank You!

Any changes in your health in the last year? ☐ Yes ☐ No
If yes please describe._____

Have you had a medical treatment/physician visit of any kind in the past year? ☐ Yes ☐ No

Are you currently under the care of a doctor? ☐ Yes ☐ No
If yes, please describe your treatment. _____

Have you ever had an surgical operations of any kind? ☐ Yes ☐ No
If yes, please describe. _____

Do you have or have you had any of the following conditions? (Please check all that apply.)

- ☐ Heat Attack/Disease
- ☐ Heart Surgery
- ☐ Heart Failure
- ☐ Hay Fever
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Anorexia/Bulimia
- ☐ Eating Disorder
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Pacemaker
- ☐ Kidney Problems
- ☐ Hives/Allergies
- ☐ Emphysema
- ☐ Asthma
- ☐ Ulcers/Digestive Problems
- ☐ Drug Addiction
- ☐ Skin Reaction to Jewelry
- ☐ Metal Allergy/Nickel
- ☐ Latex Allergy
- ☐ Diabetes/Hypoglycemia
- ☐ Thyroid Disease
- ☐ Cancer/Malignancies
- ☐ Radiation/Chemotherapy
- ☐ Arthritis/ Rheumatism
- ☐ Click or Pain in Jaw
- ☐ Psychiatric Treatment
- ☐ Liver Disease
- ☐ Seizure Disorder
- ☐ Angina
- ☐ Ear Infections
- ☐ Cold Sores
- ☐ Canker Sores
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Hepatitis A, B, C
- ☐ Headache/Migraine
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Artificial Heart Valve
- ☐ Epilepsy
- ☐ Jaundice
- ☐ Nervousness
- ☐ Bruise Easily
- ☐ Hemophilia
- ☐ Artificial Joint Hip/Knee
- ☐ Blood Disorder
- ☐ Excessive Bleeding
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Tuberculosis (TB)
- ☐ Anemia

Are you pregnant? ☐ Yes ☐ No If yes, due date: _____

Do you smoke? ☐ Yes ☐ No Do you use smokeless tobacco? ☐ Yes ☐ No

Have you been told to take antibiotics before any dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Please list any medications you are currently taking: (Prescription and Nonprescription)

_____

_____

Have you had any unfavorable reactions to any of the following? (Please check all that apply.)

☐ Aspirin ☐ Codeine ☐ Anesthetics ☐ Novocaine ☐ Penicillin ☐ Sulpha Drugs
☐ Glutaraldehyde ☐ Latex ☐ Other drugs

I certify the above to be true to the best of my knowledge

Signature: _____ Date: _____

Signature on File

The Undersigned herby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for service rendered or for service to be rendered, without obtaining my signature on each an every claim to be submitted for myself and/or dependents, and that I will be bound by this signature, as though the undersigned had personally signed the particular claim.

I _____ herby authorize
(Name of Insured)

_____ to pay and hereby
(Name of Insurance Company)

Assign directly to Yahnke Dental, all dental benefits, if any, otherwise payable to me for their services as described on the attached form. I understand I am financially responsible for all charges incurred for the dental treatment provided. Authorization is, herby, given to release all information necessary to the payment of said benefits.

_____ Date:_____
Signature of Covered Person/Employee