Dental on 21st

Jessica L. Yim, DMD
1010 N 21st Street
Newark, Ohio 43055

Welcome to our office!
We would like to get to know you better.
Please fill out this form as completely as you can.

Patient Information

Name: _____ Preferred Name: _____

D.O.B. _____ Gender: _____ Marital Status: _____

S.S.N. _____ Driver's License #: _____

Street Address: _____ Apt. / Unit: _____

City: _____ State: _____ ZIP: _____

Mobile phone: _____ Home phone: _____ Email: _____

Can we contact you through email or text? *Yes* *No*

How did you hear about our office?
(If there was a personal referral, please provide their name so we can thank them!)

Dental History

Reason for today's visit? _____ Last dental visit? _____

Have you ever had any serious problems with dental treatment? *Yes* *No*
Do you feel discomfort in any of your teeth? *Yes* *No*
Do your teeth bleed when you brush or floss? *Yes* *No*
Do you have joint/jaw pain? *Yes* *No*
How often do you brush daily? ____ Floss? ____

Any other dental questions or concerns that have not been covered above?

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Insurance Information

Name of Insured: _____ Relationship to Patient: _____

D.O.B. _____ Occupation: _____ Employer: _____

Group #: _____ ID# / SSN: _____

Dental Insurance: _____

Secondary coverage? Y / N

Name of Insured: _____ Relationship to Patient: _____

D.O.B. _____ Occupation: _____ Employer: _____

Group #: _____ ID# / SSN: _____

Please use this space to let us know anything else that will help our office to serve you better:

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to *Dental On 21st* 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Our office complies with all federal HIPAA regulations regarding privacy of patient information. A copy of privacy policies is available upon request.

Financially Responsible Party Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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Medical History

Patient Name: _____

Please circle (Y) for "yes", or (N) for "no" for any of the following which may apply to you now, or in the past:

Heart attack or heart problems	Yes	No	Fainting or blackouts	Yes	No
Congenital heart disease	Yes	No	Digestive disorder	Yes	No
Chest pain with exercise (angina)	Yes	No	Asthma	Yes	No
High blood pressure	Yes	No	Stroke or stroke history	Yes	No
Heart valve disorder	Yes	No	Drug or alcohol dependency	Yes	No
Pacemaker	Yes	No	Kidney or liver problem	Yes	No
Psychiatric disorders	Yes	No	Cancer, tumors or radiation	Yes	No
Implant or artificial joint	Yes	No	Osteoporosis or osteopenia	Yes	No
Diabetes	Yes	No	Headaches or migraines	Yes	No
Anemia or blood disorder	Yes	No	Epilepsy or seizures	Yes	No
Ulcers, reflux or heartburn	Yes	No	AIDS or HIV infection	Yes	No
Thyroid disease	Yes	No	Tuberculosis or lung problems	Yes	No
Excessive bleeding	Yes	No	Hepatitis A, B, C, or D	Yes	No

Please explain any conditions marked "Yes" above:

Are you pregnant?	Yes	No	*If yes, when are you due?* _____
Are you breastfeeding?	Yes	No	
Do you smoke?	Yes	No	*If yes, how many per day?* _____
Have you been hospitalized in the last two years?	Yes	No	

If yes, please explain:

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Medical History

Patient Name: _____

Physician's name and phone:_____

Have you ever had an allergic reaction to a drug such as penicillin, sedative, latex, aspirin, or metals? Yes No

If yes, please describe the reaction :

Please list all prescription or over-the-counter drugs, medications, or vitamins you are currently taking, or write "NONE." If you carry a list of medications, please provide us a copy.

Responsible party (print): _____ Relationship (if other): _____

Signature: _____ Date: _____