

Dr. Kenneth Yorgey, DMD PC - NEW PATIENT WELCOME FORM
804-932-5396 3215 Rock Creek Villa Drive, Suite F Quinton VA 23141

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with your child.

PATIENT INFORMATION

Child's Name _____ SSN _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Home # _____ Cell # _____ Email _____

Sex Male/Female Age _____ Birthdate _____ School _____

Grade _____ Hobbies/Sports _____

Whom may we thank for referring you? _____

Emergency Contact _____ Home # _____

Cell # _____ Business # _____ Email _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Child _____ Birthdate _____ SSN _____

Address (if different from child) _____ City _____

State _____ Zip _____ Home # _____ Cell # _____

Person Responsible Employed By _____ Occupation _____

Business Address _____

Business # _____ Business Email _____

Insurance Company _____ Phone # _____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name(s) of other dependent(s) under this plan _____

ADDITIONAL INSURANCE

Is child covered by additional insurance? Yes/No Subscribers Name _____

Relationship to Child _____ Birthdate _____ SSN _____

Address (if different from child) _____ City _____

State _____ Zip _____ Home # _____ Cell # _____

Person Responsible Employed By _____ Occupation _____

Business Address _____

Business # _____ Business Email _____

Insurance Company _____ Phone # _____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name(s) of other dependent(s) under this plan _____

Please complete the next section.

DENTAL HISTORY

What would you like us to do for your child today? _____

Former Dentist _____ Address _____ Phone # _____

Date of last dental care _____ Date of last X-rays _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? Yes/No

Has your child ever experienced a mouth or chin injury? Yes/No

Does your child have speech problems? _____

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Yes/No

Other information about your child's dental health or previous treatment _____

MEDICAL HISTORY

Child's Physician _____ Phone # _____

Date of last visit _____ Has your child had any serious illnesses or operations? Yes/No

If yes, please describe _____

Is your child currently under physician care? Yes/No If yes, please describe _____

Has your child ever had a blood transfusion? Yes/ No If yes, please give approximate dates _____

Has your child ever taken Fen-Phen/Redux? Yes/No

Please check, if your child has had any of the following (check all that apply):

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Hemophilia/Abnormal bleeding | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immunizations current | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease/malfunction | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Thyroid disease/ malfunction |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Rheumatic/Scarlet fever | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cough, persistent | Describe _____ | | Describe _____ |

List medications your child is taking, if any _____ List drug allergies, if any _____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.