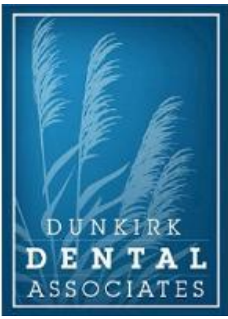

DUNKIRK DENTAL ASSOCIATES

Yuey Moy, D.D.S. Ashley Moy, D.D.S. Mark Frazer, D.D.S.

The benefits of a happy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for your dental needs.

Patient Information

Date: _____________

First Name: _______________________ Last: __________________________ MI: ______ I prefer to be called: __________________

(Circle one) Mr Mrs Ms Miss Dr.

Address: ____ City: ______________________ State: ______ Zip: ______

Home #: _____________________ Work #:______________________ Ext: ________ Cell #: _________________________________

Date of Birth: _________________ Sex (M) _______ (F) _______ Age: _______ S.S #: _________________________________

Previous Dental Office: ____ Date of Last Cleaning Appointment: __________________

Date of Previous X-Rays: _________________________ Dental Concern or Issue: ____

Employer: ____ Address: ____

E-mail: ____ May we send appointment reminders, statements, etc, via email? Yes/No

Spouse's Name: _________________________________ Phone: _____________________ Address: ______________________________

****Person Responsible for Account**: ____________________________ Relationship: _________________ S.S. #: __________________

Address: ____ Contact #: ___________________ DOB: ___________________

Emergency Contact Name: ________________________________ Hm Phone #: ___________________ Cell #: ___________________

****How or by whom did you hear about our practice?** ____________________________ Relationship: ___________________________

Other family members seen in our office: ____

Dental Insurance

Subscriber's Name: _____________________________________ DOB: _________________ Hm Phone #: _________________

Cell #: __________________ Subscribers Address: ____ Zip: __________

****Subscriber's Employer Name: ____ Union #: ________________________**

Subscriber's Employer Address: ____ Zip: ____________

Subscriber's S.S. # or ID#: ____ Employers Phone #: ____________________

Insurance Co. Name: ____ Policy or Group #: ______________________

Insurance Co. Address: ____

Zip: _____________ Insurance Co. Phone #: ___________________________ Effective Date: ____________________________

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my or my chills medical status. I authorize the dental staff to perform any necessary dental service that may be needed during diagnosis and treatment with my informed consent.

I understand that I am responsible for all changes incurred regardless of my insurance status. Changes not paid within ninety (90) days by my insurance will be the patient's responsibility. I further agree, I the event of default due to nonpayment, to be responsible for collection fees, court cost and/or legal fees and there will be a fee for all returned checks. I hereby direct benefits payable to attending dentist.

Our office is HIPPA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA. Please, review the HIPPA Privacy Statement located in the waiting room.

If you have any questions at anytime, please ask us, we are happy to help.

Signature: ____ **Date**: ___________________

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No ______________________

Are you on a special diet? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______________________

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No ______________________

Comments: ______________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENTS, or GUARDIAN ______________________ Date: __________