Dr. Reymarie Yabut, DMD
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DrYabutSmile.com

*Our Goal is Healthy Teeth and Gums for the Whole Family!*

# PATIENT INFORMATION
# DENTAL & MEDICAL HISTORY

Name: _____

Date of Birth: _____ (m / d / y)

Preferred Name: _____ Preferred Pronouns: _____

A parent, guardian or substitute decision maker will be responsible for decisions about your dental treatment? ◯ YES ◯ NO

Name of Parent / Guardian / Substitute Decision Maker (if applicable): _____

Street Address: _____

City: _____ Postal Code: _____ Phone Number: _____

E-Mail: _____

Preferred method of contact: ◯ Phone ◯ Email ◯ Text How did you hear about our office? _____

Emergency contact: _____ Relationship: _____

Phone Number of Emergency Contact: _____

Family Physician: _____ Phone Number: _____

Do you have dental insurance? ◯ YES ◯ NO

1) Member Name: _____ Date of Birth: _____ (m / d / y)

Insurance Company: _____ Policy Number: _____ Certificate Number: _____

2) Member Name: _____ Date of Birth: _____ (m / d / y)

Insurance Company: _____ Policy Number: _____ Certificate Number: _____

## DENTAL HISTORY

What is the reason for your dental visit? _____

Last Dental Visit: _____ (m / d / y) Last Dental Cleaning: _____ (m / d / y)

Please check YES or NO. If not sure, please check NS.

| | | | |
|---|---|---|---|
| Are you suffering from pain now? | ◯ YES ◯ NO ◯ NS | Do you clench or grind your teeth while asleep? | ◯ YES ◯ NO ◯ NS |
| Are any of your teeth becoming loose? | ◯ YES ◯ NO ◯ NS | Do you bite your lips or cheeks regularly? | ◯ YES ◯ NO ◯ NS |
| Have any of your teeth shifted? | ◯ YES ◯ NO ◯ NS | Do you hold foreign objects with your teeth? | ◯ YES ◯ NO ◯ NS |
| Does food get caught between your teeth? | ◯ YES ◯ NO ◯ NS | Do you breath through your mouth while awake or asleep? | ◯ YES ◯ NO ◯ NS |
| Are any teeth sensitive to pressure or temperature? | ◯ YES ◯ NO ◯ NS | | |
| Is there any swelling or pain in your gums? | ◯ YES ◯ NO ◯ NS | | |
| Is there a history of gum disease in your family? | ◯ YES ◯ NO ◯ NS | Do you have any of the following: | |
| Do you notice any bleeding from your gums? | ◯ YES ◯ NO ◯ NS | Clicking/popping of jaw when opening/closing? | ◯ YES ◯ NO ◯ NS |
| Have you had local anesthetic (freezing)? | ◯ YES ◯ NO ◯ NS | Pain (in jaw joints - ear, side of face, migraines)? | ◯ YES ◯ NO ◯ NS |
| Did you have any complications from local anesthetic? | ◯ YES ◯ NO ◯ NS | Difficulty in opening or closing your mouth? | ◯ YES ◯ NO ◯ NS |
| Do you have burning sensation of lips or tongue? | ◯ YES ◯ NO ◯ NS | Pain and/or difficulty in chewing? | ◯ YES ◯ NO ◯ NS |
| Does your mouth tend to get dry? | ◯ YES ◯ NO ◯ NS | Have you ever had surgery on your jaw joints? | ◯ YES ◯ NO ◯ NS |
| Do you have a bad taste in your mouth or bad breath? | ◯ YES ◯ NO ◯ NS | Wear a nightguard? | ◯ YES ◯ NO ◯ NS |
| Do you use any fluoride/mouth rinses? | ◯ YES ◯ NO ◯ NS | Please check off the following treatments you've had: | |
| Do you use a manual toothbrush? | ◯ YES ◯ NO ◯ NS | Orthodontic treatment (braces)? | ◯ YES ◯ NO ◯ NS |
| Do you use an electric toothbrush? | ◯ YES ◯ NO ◯ NS | Oral Surgery? | ◯ YES ◯ NO ◯ NS |
| How often do you brush your teeth per day? | ◯ 0 ◯ 1 ◯ 2 | Periodontal treatment (gum surgery)? | ◯ YES ◯ NO ◯ NS |
| How often do you floss your teeth per week? | ◯ 0 ◯ 1-3 ◯ 7 | Worn a bite plate or other appliance? | ◯ YES ◯ NO ◯ NS |
| Do you like your smile? | ◯ YES ◯ NO ◯ NS | Dental implant? | ◯ YES ◯ NO ◯ NS |
| Are you nervous about having dental treatment? | ◯ YES ◯ NO ◯ NS | | |

What would you like to change about your teeth? _____

Have you had a bad experience in a dental office? ◯ YES ◯ NO If yes, please explain: _____

**MEDICAL HISTORY**

Date of last medical check-up: _____

If you have or ever had any of the following medical conditions listed below, please check:

- ◯ Anemia
- ◯ Arthritis
- ◯ Artificial or Prosthetic Bones / Joints / Valves
- ◯ Asthma
- ◯ Autoimmune Disease
- ◯ Blood Transfusion
- ◯ Cancer
- ◯ Chemotherapy / Radiation Treatment
- ◯ Chest Pain / Angina
- ◯ Colitis
- ◯ COPD
- ◯ Diabetes Type 1 / Type 2
- ◯ Drug / Alcohol Dependency
- ◯ Epilepsy / Seizures / Fainting Spells
- ◯ Glaucoma
- ◯ Head / Neck Injuries
- ◯ Heart Murmur
- ◯ Heart Attack
- ◯ Heart Surgery / Pacemaker
- ◯ Hemophilia / Abnormal Bleeding
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ Herpes / Cold Sores
- ◯ High Cholesterol
- ◯ HIV / AIDS
- ◯ Hormonal Imbalance
- ◯ Hypertension (High Blood Pressure)
- ◯ Hypotension (Low Blood Pressure)
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Local Anesthetic Sensitivity
- ◯ Mental Illness
- ◯ Migraines / Frequent Headaches
- ◯ Mitral Valve Prolapse
- ◯ Osteoporosis
- ◯ Respiratory Illness
- ◯ Rheumatic / Scarlet Fever
- ◯ Sexually Transmitted Disease
- ◯ Shingles
- ◯ Sinus Problems
- ◯ Stroke
- ◯ Thyroid Disease
- ◯ Tuberculosis (TB)
- ◯ Ulcers

Please list any current medical conditions, hospitalizations or recent surgeries you've had:

_____

Are you taking any prescription by a physician or over the counter drugs? ◯ YES ◯ NO

Please list current medications, non-prescription drugs or herbal supplements including dosage and when medication is taken:

_____

_____

Are you allergic to any of the following? If so, please check.

- ◯ Ibuprofen (Advil)
- ◯ Aspirin
- ◯ Tylenol
- ◯ Tylenol #2, #3, #4
- ◯ Nembutal
- ◯ Seconal
- ◯ Naproxen
- ◯ Toradol
- ◯ Codeine
- ◯ Demerol
- ◯ Percodan
- ◯ Darvon
- ◯ Valium
- ◯ Ampicillin
- ◯ Penicillin
- ◯ Erythromycin
- ◯ Clindamycin
- ◯ Scopolamine
- ◯ Tetracycline
- ◯ Rovamycin
- ◯ Celphaxin
- ◯ Sulpha Drugs
- ◯ Metal
- ◯ Latex
- ◯ Local Anesthetic (Freezing)
- ◯ Nitrous Oxide
- ◯ Amoxicillin
- ◯ Chlorhexidine (Peridex)
- ◯ Adhesive Bandages

Please list any other allergies or any adverse reaction to any food, medication or other item:

_____

Do you smoke or use tobacco in any other form? ◯ YES ◯ NO

Cigarettes per day: _____ How many years have you been using tobacco products? _____

Do you use cannabis? ◯ YES ◯ NO If yes, please check: ◯ Medicinal ◯ Recreational ◯ Both How often? _____

Are you currently pregnant or breastfeeding? ◯ YES ◯ NO ◯ Not Sure / Maybe

I certify that I have read, understood, and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist to perform necessary diagnostic procedures and treatment, including local anesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided if my insurance coverage may not be all inclusive. I know your office has a privacy code, and I can ask to see the code any time. I agree that your office can collect, use, and disclose personal information about as set out in your office privacy policy. I authorize the release to my insuring company plan administrator, the information contained in claims submitted electronically.

◯ Patient ◯ Parent ◯ Guardian Signature: _____ Date Signed: _____

Dentist's Notes: _____

Dentist Signature: _____ Date Signed: _____

# PATIENT PRIVACY CONSENT FORM - For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, the Privacy Information Officer is: **DR. REYMARIE YABUT DENTISTRY PROFESSIONAL CORPORATION**

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.
In this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols;
- Our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.
Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

**How Our Office Collects, Uses and Discloses Patients' Personal Information**

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.
This office will collect, use and disclose information about you for the following purposes:

- To delivery safe and efficient patient care
- To identify and to ensure continuous high quality service
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services
- To communicate with other treatment health-care providers, including specialists and referring doctors
- To allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit claims for third party adjudication and payment
- To comply with legal regulatory requirements, including the delivery of patients' charts and records to governing bodies in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- To comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to evaluate the practice
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- To prepare materials for the Health Professions Appeal and Review Board (HPARB)
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with regulatory requirements
- To comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we seek your approval in advance. Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue. Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

**Patient Consent**

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that **DR. REYMARIE YABUT DENTISTRY PROFESSIONAL CORPORATION (DR. YABUT SMILE)** can collect, use and disclose personal information about _____ (Patient Name) as set out above in the information about the office's privacy policies.

PATIENT NAME: _____ PATIENT SIGNATURE: _____

DATE: _____ WITNESS SIGNATURE: _____

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Dear Dr. _____, I hereby consent to, authorize, and request the release of my/our dental records and any radiographs to Dr. Reymarie Yabut.

Family members to be transferred: (1) _____ (2) _____

(3) _____ (4) _____

Date of last Comprehensive Oral Exam: (1) _____ (2) _____

(3) _____ (4) _____

Date of last FMX/PAN: (1) _____ (2) _____

(3) _____ (4) _____

Date of last Recall and Bitewings: (1) _____ (2) _____

(3) _____ (4) _____

Signature of Patient/Parent/Guardian: _____

Print Name: _____

Date of Birth: _____

Date: _____

Please e-mail information and radiographs to info@DrYabutSmile.com.

**Thank you very much and hoping for your immediate response regarding this matter.**