

Scott Young, D.D.S.
Cosmetic & Reconstructive Dentistry
6769 Lake Woodlands Dr., Suite G, The Woodlands, TX 77382
281.367.5559 / 281.465.8737 facsimile

GUEST INFORMATION (Please Print)

Date: ___/___/___

Name _____ **Birthdate** ___/___/___
First MI Last

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email Address _____ **Prefer appt. confirmation via email?** _____

SS# _____ **Circle One: Minor Single Married Divorced Widowed**

How did you hear about Dr. Young? _____

If guest is a student, name of school or college _____ **PT or FT**

If guest is a minor: Parent's Name _____ **SS#** _____

Guest's or Parent's Employer _____ **Work Phone** _____

RESPONSIBLE PARTY (If different from above)

Name of person responsible for this account _____ **Relationship** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____ **Birthdate** ___/___/___

SS# _____ **Name of Employer** _____

Insurance Company _____ **Group#** _____ **Phone#** _____

FINANCIAL POLICY

I have read and agree to the financial policies of this office.

Signature **Date:** ___/___/___

MEDICAL HISTORY

Date: ___/___/___

Name _____

Birthdate: ___/___/___

Physician _____ Office Phone: _____ Date of Last Exam: ___/___/___

1. Are you under medical treatment now? YES NO

2. Are you taking any medication(s) including non-prescription medicine? YES NO

If Yes, what medication(s) are you taking? _____

3. Do you use tobacco? YES NO

4. Do you wear contact lenses? YES NO

5. Are you allergic to or have you had any reactions to any drugs? If yes, please specify.

___ No known allergies
YES: _____

6. Women only:

A) Are you pregnant or think you might be pregnant? YES NO

B) Are you nursing? YES NO

C) Are you taking birth control pills? YES NO

Please indicate which of the following applies to you. Check only if answer is yes.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hepatitis: A B or C |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Aids or HIV Infection |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Stomach Trouble/Ulcers |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Hay Fever / Allergies | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney Diseases | <input type="checkbox"/> Joint Replacement or Implant Where? _____ | |
| <input type="checkbox"/> Chest Pains | | | |

Comments: _____

DENTAL HISTORY:

Previous Dentist: _____ Last Dental Visit: ___/___/___

Reason for changing: _____

Please answer the following questions with a "Y" for yes or "N" for no.

- | | |
|---|---|
| <input type="checkbox"/> Do your gums bleed while brushing or flossing? | <input type="checkbox"/> Have you ever had any difficult extractions in the past? |
| <input type="checkbox"/> Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> Have you had orthodontic work? |
| <input type="checkbox"/> Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> Have you had prolonged bleeding following extractions? |
| <input type="checkbox"/> Do you feel pain to any of your teeth? | <input type="checkbox"/> Do you have extreme anxiety about dental procedures? |
| <input type="checkbox"/> Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> Have you experienced difficulty becoming numb for dental procedures? |
| <input type="checkbox"/> Have you had any head, neck or jaw injuries? | <input type="checkbox"/> Have you had instructions on the care of your gums? |
| <input type="checkbox"/> Have you ever experienced any of the following problems in your jaw? | <input type="checkbox"/> Have you ever had instruction on the correct method of brushing of your teeth? |
| <input type="checkbox"/> Clicking? | <input type="checkbox"/> Do you use an electric toothbrush? Model? _____ |
| <input type="checkbox"/> Pain (Joint, Ear, Side of face)? | <input type="checkbox"/> Are you satisfied with the appearance of your teeth? |
| <input type="checkbox"/> Difficulty in opening or closing? | <input type="checkbox"/> Are you interested in learning more about Zoom!, an in-office whitening procedure, as seen on ABC's hit show <i>Extreme Makeover</i> ? |
| <input type="checkbox"/> Difficulty in chewing? | |
| <input type="checkbox"/> Do you have frequent headaches? | |
| <input type="checkbox"/> Do you clench or grind your teeth? | |
| <input type="checkbox"/> Do you bite your lips or cheeks frequently? | |

I certify that I have read and understand the above information, and to the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____
Guest, Parent or Guardian

Date ___/___/___

Scott Young D.D.S.
Consent for Use and Disclosure of Health Information

Patient Giving Consent:

Name: _____

Address: _____

Telephone: _____

Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice is available with this consent.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Scott Young, D.D.S. 6769 Lake Woodlands Dr. Ste. G, The Woodlands, TX 77382
281 367-5559 / 281 465-8737 (facsimile)

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and you Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: _____ **Relationship:** _____