DAVID YOUNAN, DDS FAMILY DENTISTRY

PATIENT WELCOME FORM

DAVID YOUNAN, DDS
MICHAEL SMOLEN, DDS

249 E. OCEAN BLVD., SUITE 102
LONG BEACH, CA 90802

(562) 432-1022

- We have designed this form to be as thorough as possible so that your future paperwork requirements will be kept to an absolute minimum. Please take the necessary time to fill in this form completely.
- Information supplied on this form is considered *confidential,* and will not be released without your written permission.
- If you have any questions about completing this form, please speak with our office staff.
- Thank you for taking time to complete this form.

Patient Information

❑ Mr.
❑ Ms.
❑ Mrs.
❑ Miss
❑ Dr.

Last First Middle Legal Name

How would you like us to address you (nickname)?

Address

City State Zip

Phone: Home Work Cell or pager

e-mail address

Would you like appointment reminders via e-mail? ❑ yes ❑ no

How often do you check your e-mail? _____

Date of Birth Sex ❑ Male ❑ Female Marital Status ❑ S ❑ M ❑ D ❑ W

Spouse's name

Full-time student ❑ yes ❑ no Where: _____

Social Security Number

Who may we thank for referring you to our office?

Who is responsible for your dental investment?

If a portion of these services will be covered by dental insurance, what is your relationship to the insured person? ❑ self ❑ spouse ❑ child ❑ other

Name of person to contact in case of emegency Phone

• Information supplied on this form is considered *confidential,* and will not be released without your written permission.

• Once again, thank you for taking time to complete this form.

Insurance Information

Name of employer providing insurance benefit

Employer address | City | State / Zip

Employer phone number

If applicable, please provide name of work contact with information regarding insurance coverage

Name of Insurance Company

Address | City | State / Zip

Phone number

Policy number | Group number

Name of Employee / Subscriber (if different than patient)

Address | City | State / Zip

Social Security Number

Date of Birth | Clock Number | Union Local

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____Birth date _____ Age_____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

		YES	NO
1.	Are you in good health now?	☐	☐
2.	Are you now under the care of a physician? If so, what is the condition being treated? _____	☐	☐
3.	Have you ever been hospitalized or had a serious illness? If yes, explain _____	☐	☐
4.	Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
5.	(Women) Are you pregnant? If so, give due date	☐	☐
6.	Do you use tobacco in any form? If yes, how much	☐	☐
7.	Do you drink alcoholic beverages (more than 2 drinks per day)?	☐	☐

8. Do you have or have you ever had any of the following?

GENERAL	YES	NO
Tire easily, weakness	☐	☐
Marked weight changes	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Eruptions	☐	☐
Change in skin color	☐	☐
EYES		
Visual change	☐	☐
Glaucoma	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Snoring and/or sleep apnea	☐	☐
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other	☐	☐

HEART/BLOOD VESSELS	YES	NO
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other	☐	☐
BONE/MUSCLES		
Arthritis/rheumatism	☐	☐
Artificial joints/limbs	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
URINARY		
Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
OTHER		
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Tumors or growth	☐	☐
Cancer	☐	☐
HIV+	☐	☐
AIDS	☐	☐

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9. Are you **ALLERGIC** or have you ever experienced any reaction to the following?

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine)	☐	☐	Aspirin or codeine	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐	Sulfa drugs	☐	☐
Penicillin/other antibiotics	☐	☐	Latex	☐	☐
			Other allergies	☐	☐

10. Are you **TAKING** any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs	☐	☐	Tranquilizers	☐	☐
Blood thinners	☐	☐	Insulin/other diabetes drugs	☐	☐
Blood pressure medication	☐	☐	Recreational drugs	☐	☐
Thyroid medicine	☐	☐	Digitalis/other heart medications	☐	☐
Cortisone/steroids	☐	☐	Nitroglycerin	☐	☐
Antihistamines/allergy drugs/ cold remedies	☐	☐	Bisphosphonates (e.g. Fosamax, Zometa)	☐	☐
			Aspirin	☐	☐
			Other medication	☐	☐

If yes to any of the above, list **NAME** of medication and **DOSAGE** below:

_____

_____

_____

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

_____

12. Physician's Name _____
13. Have you ever had any serious trouble associated with previous dental treatment? _____

_____

14. Does dental treatment make you nervous?No_____Slightly_____Moderately_____Extremely_____
15. Date of your last dental visit?_____
16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?_____
17. Are you dissatisfied with the appearance of your teeth?_____
18. Do you want complete dental care?_____

19. Do you have or have you ever had any of the following?

MOUTH

	YES	NO
Bleeding, sore gums	☐	☐
Unpleasant taste/bad breath	☐	☐
Burning tongue/lips	☐	☐
Frequent blisters, lips/mouth	☐	☐
Swelling/lumps in mouth	☐	☐
Ortho treatment (braces)	☐	☐
Biting cheeks/lips	☐	☐
Clicking/popping jaw	☐	☐
Difficulty opening or closing jaw	☐	☐

TEETH

	YES	NO
Loose teeth	☐	☐
Sensitive to hot	☐	☐
Sensitive to cold	☐	☐
Sensitive to sweets	☐	☐
Sensitive to biting	☐	☐
Food impaction	☐	☐
Clenching/grinding	☐	☐
Shifting of teeth	☐	☐
Change in bite	☐	☐

ORAL HYGIENE

Do you use the following?	YES	NO
Brush	☐	☐
Dental floss	☐	☐
Fluoride rinse	☐	☐

Other _____

How often do you brush_____

Brush is: Soft ☐ Medium ☐ Hard ☐

If Electric: Brand _____

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.
Signature of Patient
Parent or Guardian_____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

SECTION B: TO PATIENT – 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 operation.

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.

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 us by phone or email.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a 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 of 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.

SECTION C: SIGNATURE

I have had full opportunity to read and consider the contents of this Consent and 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 of Birth: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

DAVID YOUNAN, DDS

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(562) 432-1022

WWW.DRYOUNAN.COM

I, _____, acknowledge I have received
(Print Name)

from David Younan, DDS a copy of the Dental Materials Fact Sheet dated May 2004, as required by law.

_____ _____

PATIENT SIGNATURE DATE