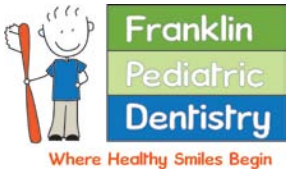

John Eric Yezerski, DMD

Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Home phone _____ Soc. Security # _____ Birthdate _____

Email (for appointment reminder) _____

Name of school _____ City _____ State _____

Whom may we thank for referring you _____

Responsible Party

Name of person responsible for this patient _____ Relationship to patient _____

Address _____ Home phone _____

Birth Date _____ Soc. Security # _____ Cell Phone _____

Email address _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

Amount of your deductible _____ Max annual benefit _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Ins. Co. address _____ City _____ State _____ Zip _____

Amount of your deductible _____ How much have you used? _____ Max annual benefit _____

In my absence, I give permission to _____ to accompany my child and consent for any needed treatment.

You agree that by ☐king "Electronic Signature" such action will constitute your electronic signature having the same legal force and effect as a hand written signature. _☐_

X _____ _____

Signature of patient (or parent, if minor) **Patient number**

Dental and Medical Health History

How often does your child brush? _____
How often does your child floss? _____

Does your child:	Yes	No
Take fluoride supplements	☐	☐
Use pacifier	☐	☐
Suck thumb or finger	☐	☐
Suck or bite lip	☐	☐
Bite or chew nails	☐	☐
Grind teeth	☐	☐
Clench jaws	☐	☐
Gag easily	☐	☐
Was your child breastfed?	☐	☐
Age discontinued_____		
Was your child bottle-fed?	☐	☐
Age discontinued_____		

Has your child ever had the following (please check if any of the below apply):

☐ asthma
☐ autism
☐ brain injury
☐ bleeding disorder
☐ cancer
☐ cerebral palsy
☐ congenital heart defect
☐ diabetes
☐ epilepsy/seizures
☐ HIV/AIDS
☐ lung problems
☐ mental disorder
☐ anemia
☐ developmental delay
☐ speech disorder
☐ tuberculosis
☐ vision disorder
☐ Other_____
_____
_____
☐ My child is healthy

If you said yes to any of the above, please explain:_____
_____
_____

Current medications taken_____

Allergies or adverse reactions to any medications (e.g. penicillin, sulfas)_____

Allergies to any substances (e.g. latex)_____

Previous hospitalizations, surgeries, or serious illnesses, and date_____

Has your child had difficulty with previous dental visits? Y N Please describe_____

_____

Date of last dental visit_____ Previous dentist_____

Child's pediatrician_____ Phone number_____

Is there anything specific you'd like to discuss with Dr. Yezerski today?_____

_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk and that it is my responsibility to inform the dental office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners as necessary.

May we request release of your child's medical records for our records?_____

With your verbal permission, you agree to release your child's records to another doctor at their/your request.

Signature of Parent/Guardian

X_____ Date_____