MARKET STREET DENTAL, P.C.

1820 East Market Street, York, PA 17402 (717) 757-3851

We are pleased that you have selected us to provide dental care for you and your family!
Whom may we thank for referring you to our office? _____

Date:_____ Patient's Name:_____
First Middle Last Nickname

Address:_____
Street Unit # City State Zip

Home Ph. #:_____ Work Ph. #:_____ Cell Ph. #:_____
Soc. Sec. #:___-___-_____ Drivers Lic. #_____ Email:_____
Age____ Birthdate:____/____/____ Sex M F Emergency Contact:_____
Relationship: _____

Employer:_____ Occupation:_____ # of yrs. Employed:____
Employer Address:_____
Street Unit # City State Zip
Spouse/Significant Other's Name:_____ Relationship to Patient:_____

INSURANCE INFORMATION

Insured's Name:_____ Insured's Soc. Sec. #:_____ Insured's DOB:_____
Relationship to Insured:_____
Insurance Company:_____ Group #:_____
Insurance Co. Address:_____ Ph #:_____
Do you have dual coverage? Yes____ No____ If yes: **Please complete the following secondary insurance information**
Insured's Name:_____ Insured's Soc. Sec. #:_____ Insured's DOB:_____
Relationship to Insured:_____
Insurance Company:_____ Group #:_____
Insurance Co. Address:_____ Ph #:_____

FINANCIAL INFORMATION

If no dental insurance, how to you intend to pay for your dental visit today?

Cash_____ Check_____ Credit Card_____ Please circle: VISA MASTERCARD DISCOVER
Other, please explain_____

MEDICAL INFORMATION

Physician's Name_____
Address City Phone #
Date of Last Physical Exam_____ Do you need **premedication** Y N If yes, why? _____

MEDICATIONS **List all medications you are taking now:**

1._____ 2._____ 3._____ 4._____
5._____ 6._____ 7._____ 8._____

ALLERGIES

1._____ 2._____ 3._____ 4._____

1. Have you been in the hospital during the last two years? Y_____ N_____
   If yes, please explain_____

2. **Indicate which of the following you have had or have at the present time. Circle each item.**

Allergy to Latex	Artificial Joints (hip, knee, etc.)	Osteoporosis	Arthritis
Heart Failure	Kidney Trouble	Hepatitis, A, B, or C	Sinus Trouble
Heart Disease or Heart Attack	Ulcers or Stomach Problems	Venereal Disease	Yellow Jaundice
Angina Pectoris	Diabetes: Insulin/Diet Controlled	A.I.D.S.	Rheumatism
Congenital Heart Disease	Thyroid Problems	H.I.V. positive	Radiation Therapy
Heart Murmur	Glaucoma	Cold Sore/Fever Blisters	Epilepsy/Seizures
High Blood Pressure	Cancer Type	Blood Transfusion	Cortisone Medicine
Arteriosclerosis	Emphysema	Hemophilia	Chemotherapy
Mitral Valve Prolapse	Chronic Cough	Anemia	Fainting Spells
Artificial Heart Valve	Tuberculosis	Sickle Cell Anemia	Drug/Alcohol Add.
Heart Pacemaker	Asthma	Bruise Easily	Developmentally Disabled
Heart Surgery	Back problems	Psychiatric Care	Nervousness
Stroke	Hay Fever	Bleeding/Clotting	Allergy to Metal
Rheumatic Fever	Allergies or Hives	Liver Disease	Tumors
Eating Disorder	Shortness of Breath	Respiratory or lung prob.	Chemical Dependency Y N
Gastric Bypass Surgery	Swollen Glands/Lymph Nodes	Botox/Dermal Fillers	Are you in Recovery? Y N

3. Have you lost or gained more than 10 pounds in the past year? _____Yes _____No
4. Do you have or have had any disease, condition or problem not listed? _____ Yes _____No. If yes please list below:

_____

5. **For Women Only:**
   Are you pregnant? ____Yes ____No
   Are you nursing? ____Yes____No
   EXPECTED DUE DATE
   What month?_____
   Are you taking birth control? ____Yes ____No

DENTAL INFORMATION

Reason for today's visit_____
Former Dentist's name_____City_____State_____
Date of last dental visit_____Date of last dental x-rays_____
Treatment performed_____Reason for changing dentist_____
Do you like your smile? ____Yes ____No If not, what would you change? _____

Please circle if you have had any of the following:

Bleeding Gums	Difficult extraction/prolong bleeding	Sleep Apnea	Smoke: cigarettes/cigars / VAPE / MEDICAL MARIJUANA
Dry Mouth	Fingernail Biting	Use snuff/chewing tobacco	Broken fillings
Unusual growths/sore spots	Mouth Piercings	Snoring Problems	Bad taste/mouth odor
Burning tongue	Teeth Sensitivity: hot/cold/sweets	Food collect between teeth	Clench or grind teeth
Migraine/Headaches	Sensitivity to pressure/chewing	Chew on one side of mouth	Difficulty getting numb
Ulcers or mouth sores	Loose Teeth (Periodontal)	Nitrous (laughing gas)	Lip or cheek biting
Traumatic Injury to teeth	Clicking or popping jaw	Orthodontic treatment	TMJ problems/pain

Allergic reaction to Novocain, local or general anesthetics?_____
How have your dental experiences been in the last?_____Excellent _____Mediocre_____Painful/Frightful
If you are frightened, what causes this?_____
Have you ever had to be pre-medicated for anxiety prior to a dental visit? What medication?_____Valium___Ativan____Xanax____Other_____
How often do you floss?_____How often do you brush_____

AUTHORIZATION AND RELEASE

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP. I AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO RELEASE THE PAYMENT OF BENEFITS. I UNDERSTAND THAT **I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.** IT WILL BE PATIENT'S RESPONSIBILITY AND/OR LEGAL GUARDIAN'S RESPONSIBILITY OF MINOR FOR ALL CHARGES OF COLLECTION AGENCIES AND/OR ATTORNEY FEES IF THEIR ACCOUNT BECOMES DELINQUENT AND SET-FORTH FOR COLLECTIONS PROCEDURES. I AUTHORIZE THE USE OF THIS SIGNATURE AND MY SOCIAL SECURITY NUMBER ON ALL INSURANCE SUBMISSIONS.

_____

Responsible Party Signature Relationship Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.
NOTE: ***A 1.8% FINANCE CHARGE WILL ACCRUE MONTLY ON ACCOUNTS 60 DAYS PAST DUE.