Yogi Dental Center
30 Scotland Rd Orange, NJ 07050 /yogidental@gmail.com /973-673-1311

Dental Patient Information Form

Reason for Today's Visit: _____

Name: _____Sex: ____ M _____F

Home Phone: _____ Work Phone:_____Cell Phone: _____

Email Address: _____

Home Address: _____City: _____ Zip Code: _____

Patient Social Security #: _____ Date of Birth:_____

Driver's License #: _____State: _____ Exp. Date: _____

Marital Status: Married Divorced Legally Separated Single

Full Time Student: Yes No Name of School: _____

Nearest relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Whom may we contact in the case of an emergency?_____ Phone:_____

Whom may we thank for referring you to us? _____ Phone:_____

Who is responsible for this bill? _____

Date of last dental exam: _____

Name of previous treating dentist: _____

Did you sustain an injury at work?
□Yes □No

Are you covered under an employer or union policy?
□Yes □No

Are your injuries accident related?
□Yes □No

Is your spouse or other family member employed?
□Yes □No

Are you currently employed?
□Yes □No

Do you have a secondary or medical insurance policy?
□Yes □No

Have you ever served in the military?
□Yes □No

Are you covered under any other health care plan?
□Yes □No

Dental Insurance Information

Name of Insured: _____

Relationship to Patient: _____

Policyholder Date of Birth: _____

Policyholder Social Security #: _____

Dental Insurance Carrier Name, Address, Phone #:

_____

Identification card present upon encounter: Yes No

Yogi Dental Center
30 Scotland Rd Orange, NJ 07050 /yogidental@gmail.com /973-673-1311

Eligibility date indicated on card as: _____

Are the medical and dental carrier the same? Yes No

Is this plan HMO, PPO or EPO Yes NO (circle the correct response)

Insured's Employer Name and Address:

_____

_____

Employer Phone#: _____

Insured's Social Security #: _____

Responsible Party Driver's License #: _____

Is there any other insurance? If so, please indicate: _____

Other Dental Insurance Information

Name of Insured: _____

Relationship to Patient: _____

Policyholder Date of Birth: _____

Policyholder Social Security #: _____

Dental Insurance Carrier Name, Address, Phone #: _____

_____

Identification card present upon encounter?: Yes No

Eligibility Date indicated on card as: _____

Are the medical and dental carrier the same: Yes No

Is this plan HMO, PPO or EPO Yes NO (circle the correct response)

Medical Insurance

If information is the same as the information above indicate with "Same" and indicate which policyholder is applicable in the appropriate data fields.

Medical Insurance Information or a third carrier

Name of Insured: _____

Relationship to Patient: _____

Policyholder Date of Birth: _____

Policyholder Social Security #: _____

Insurance Carrier Name, Address, Phone #:

_____

_____

Identification card present upon encounter: Yes No

Eligibility date indicated on card as: _____

Is this plan HMO, PPO or EPO Yes NO (circle the correct response)

If this is for EHB; who administers the plan: _____

Secondary Medical Insurance

If information is same as the information above indicate with "Same as and indicate which policyholder is applicable" in the appropriate data fields.

Medical Insurance Information or a third carrier

Name of Insured: _____

Relationship to Patient: _____

Policyholder Date of Birth: _____

Policyholder Social Security #: _____

Insurance Carrier Name, Address, Phone #: _____

Identification card present upon encounter: Yes No

Eligibility date indicated on card as: _____

Is this plan HMO, PPO or EPO Yes NO (circle the correct response)

If this is for EHB; who administers the plan? _____

Accident or Injury Information

If this claim is accident related: Yes No

If yes, please provide details of the accident:

Date: _____

Location:_____

Details of accident or injury:

_____

_____

_____

Did you consult another medical physician regarding any other injuries resulting from this accident?

Name of physician: _____

Date first seen by other physician: _____

Could this injury be covered under Worker's Compensation? Yes No

There are dental conditions that may have a medical complications or etiology. To best assist our patients we find having all information a valuable resource in determining the patient needs and insurance coverage.

Have you experienced weight loss? Yes No. How much lost weight?_____

Are you currently under the care of a physician? _____

Are you allergic to latex? Yes No

Have you been diagnosed with sleep apnea? Yes No

Yogi Dental Center
30 Scotland Rd Orange, NJ 07050 /yogidental@gmail.com /973-673-1311

Have you been tested for sleep apnea? Yes No

Have you been diagnosed with TMJ or TMJD? Yes No

Have you received treatment for TMJ or TMJD? Yes No

Are you allergic to penicillin, aspirin or other drugs? _____

Have you ever had a reaction to Novocain or Anesthesia? Yes No Date:_____

If so, please explain: _____

Dental History

Chief Complaint (reason for your visit today) _____

Previous History of the chief complaint? Yes No

When: _____

Treated by: _____

Past or Present History of (circle all that apply):

Accidental injury to teeth/mouth	Blisters on lips	Blisters in mouth
Blisters or burning of tongue	Chew on one side of mouth	Clench/ grind teeth
Dental fractures	Dry mouth	Growths/ lesions in mouth
Gums swollen, tender /bleeding	Head, neck, jaw pain,	Lip or cheek biting
Loose teeth or broken fillings	Mouth breathing	Orthodontic treatment
Nitrous Oxide	Periodontal treatment	Sensitivity to hot/cold

How often do you visit the dentist? _____

How often do you floss? _____

How often do you brush your teeth? _____

Are you in pain at this time? _____

For how long have you been in pain? _____

Is your pain due to an accidental injury or accident?_____

Explain: _____

Is the damaged tooth a capped or previously restored tooth? _____

When was the previous work performed?_____

Are there any other health conditions you have that are not listed? Yes No

If so, please explain:

_____

Please list all allergies:

_____

Please list all medications you are taking:

_____

Yogi Dental Center
30 Scotland Rd Orange, NJ 07050 /yogidental@gmail.com /973-673-1311

Women Only:

Are you pregnant? Yes No Nursing? Yes No Had an exposure to HPV? Yes No

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential. I am aware that a copy of my insurance identification card will be made available and a copy kept in my records. I am responsible for updating this information if and when there are changes.

Signature

Date