DENTAL HISTORY

Referred by________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist ________________ How long have you been a patient?__________ Months/Years

Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) _____/_____/_____ Year of most recent cleaning__________

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? * ________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY — YES / NO

1. Are you fearful or anxious of dental treatment? How much, on a scale of 1 (least) to 10 (most) [ ] ________ ☐ ☐
2. Have you had an unfavorable dental experience or complications with treatment? ________ ☐ ☐
3. Have you ever had trouble getting numb or had any reactions to local anesthetic? * ________ ☐ ☐
4. Did you ever have braces, orthodontic treatment or had your bite adjusted? ________ ☐ ☐

SMILE CHARACTERISTICS — YES / NO

5. Is there anything about the appearance of your teeth that you would like to change? ________ ☐ ☐
6. Do you ever wish you had a whiter smile? ________ ☐ ☐
7. Have you felt uncomfortable or self conscious about the appearance of your teeth? ________ ☐ ☐
9. Have you been disappointed with the appearance of previous dental work? ________ ☐ ☐

BITE AND JAW JOINT — YES / NO

10. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping, ear ringing) ________ ☐ ☐
11. Do you / would you have any problems chewing gum or any hard food? ________ ☐ ☐
12. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ________ ☐ ☐
13. Are your teeth crowding or developing spaces? ________ ☐ ☐
14. Do you have more than one bite and squeeze to make your teeth fit together? ________ ☐ ☐
15. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ________ ☐ ☐
16. Do you clench your teeth in the daytime or make them sore or grind them at night? ________ ☐ ☐
17. Do you wear or have you ever worn a bite appliance? ________ ☐ ☐

TOOTH STRUCTURE — YES / NO

18. Have you had any cavities within the past 3 years? ________ ☐ ☐
19. Does the amount of saliva in your mouth seem too little? ________ ☐ ☐
20. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ________ ☐ ☐
21. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ________ ☐ ☐
22. Do you have grooves or notches on your teeth near the gum line? ________ ☐ ☐
23. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ________ ☐ ☐
24. Do you get food caught between any teeth? ________ ☐ ☐

GUM AND BONE — YES / NO

25. Do your gums ever bleed when brushing or flossing? ________ ☐ ☐
26. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ________ ☐ ☐
27. Have you ever noticed an unpleasant taste or odor in your mouth, or been told that you do? ________ ☐ ☐
28. Is there anyone with a history of periodontal or gum disease in your family? ________ ☐ ☐
29. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ________ ☐ ☐
30. Have you experienced a burning sensation in your mouth? ________ ☐ ☐

Patient's Signature * ________________ Date__________

Doctor's Signature ________________ Date__________

*forms completed digitally will be signed in person when you arrive at our office.

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ________

Name of Physician/and their specialty ______________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury ______	☐	☐
2.	an allergic reaction to ☐ None, I have no allergies, None ☐ aspirin, ibuprofen, acetaminophen, codeine ☐ penicillin ☐ erythromycin ☐ tetracycline ☐ sulpha ☐ local anesthetic ☐ fluoride ☐ metals (nickel, gold, silver, ______) ☐ latex ☐ other ______		
3.	heart problems, or cardiac stent within the last six months ______	☐	☐
4.	history of infective endocarditis, bacterial ______	☐	☐
5.	artificial heart valve, repaired heart defect (PFO) ______	☐	☐
6.	pacemaker or implantable defibrillator ______	☐	☐
7.	artificial prosthesis (joints) ______	☐	☐
8.	rheumatic or scarlet fever ______	☐	☐
9.	high or low blood pressure ______	☐	☐
10.	a stroke (taking blood thinners) ______	☐	☐
11.	prolonged bleeding due to a slight cut (INR > 3.5) ______	☐	☐
12.	emphysema, sarcoidosis, COPD ______	☐	☐
13.	tuberculosis ______	☐	☐
14.	asthma ______	☐	☐
15.	breathing or sleep problems (i.e. snoring, sinus) ______	☐	☐
16.	kidney disease ______	☐	☐
17.	liver disease ______	☐	☐
18.	thyroid, parathyroid disease, or calcium deficiency ______	☐	☐
19.	hormone deficiency ______	☐	☐
20.	high cholesterol or taking statin drugs ______	☐	☐
21.	diabetes (HbA1c = ______) ______	☐	☐
22.	stomach or duodenal ulcer ______	☐	☐
23.	digestive disorders (i.e. gastric reflux) ______	☐	☐
24.	osteoporosis/osteopenia (i.e. taking bisphosphonates) ______	☐	☐
25.	arthritis ______	☐	☐
26.	glaucoma ______	☐	☐
27.	head or neck injuries ______	☐	☐
28.	epilepsy, convulsions (seizures) ______	☐	☐
29.	neurologic problems (attention deficit disorder) ______	☐	☐
30.	viral infections and cold sores ______	☐	☐
31.	any lumps or swelling in the mouth ______	☐	☐
32.	venereal disease ______	☐	☐
33.	hepatitis (type ___) ______	☐	☐
34.	HIV / AIDS ______	☐	☐
35.	tumor, abnormal growth ______	☐	☐
36.	radiation therapy ______	☐	☐
37.	chemotherapy ______	☐	☐
38.	emotional problems ______	☐	☐
39.	psychiatric treatment ______	☐	☐
40.	antidepressant medication ______	☐	☐
41.	alcohol / drug dependency ______	☐	☐
42.	COVID-19 positive ______	☐	☐

ARE YOU:

		YES	NO
43.	presently being treated for any other illness ______	☐	☐
44.	aware of a change in your general health ______	☐	☐
45.	taking medication for weight management (i.e. fen-phen)	☐	☐
46.	taking dietary supplements ______	☐	☐
47.	subject to frequent headaches ______	☐	☐
48.	a smoker or smoked previously ______	☐	☐
49.	FEMALE - taking birth control pills ______	☐	☐
50.	FEMALE - pregnant ______	☐	☐
51.	MALE - prostate disorders ______	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

____

List all medications, supplements, and or vitamins you are currently taking.

Drug	Purpose	Drug	Purpose

Patient's Signature * ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

Updated History ______________ Date ________ Updated History ______________ Date ________

Updated History ______________ Date ________ Updated History ______________ Date ________

*forms completed digitally will be signed in person when you arrive at our office.

Scott A Young DDS (e) scottayoungdds@gmail.com (w) 704 541 5900 (f) 704 541 5454

PATIENT INFORMATION

PATIENT'S LEGAL NAME (First, MI, Last)

____ DOB______________ Age_____

PREFER TO BE CALLED________________________ SOCIAL SECURITY #________________

Sex: M____ F____ Marital Status: Married Single

ADDRESS:____________________________________CITY_____________STATE____ZIP______

PHONE #'S
HOME________________WORK__________________Ext_____CELL__________________

EMAIL ADDRESS ________________________

NAME OF EMPLOYER_______________________________OCCUPATION ________________

STUDENT STATUS: FULL TIME____PART TIME ____ SCHOOL/COLLEGE__________________________

NAME OF PARENT OR LEGAL GUARDIAN____________________________PH#________________

ADDRESS (IF DIFFERENT FROM PATIENT____

EMERGENCY CONTACT INFORMATION:

NAME OF CONTACT_______________________________RELATIONSHIP TO PATIENT____________

HOME PH#______________WORK#_____________CELL#________________

ARE YOU COVERED BY INSURANCE? YES______ NO______

POLICY HOLDER'S NAME_________________________________DATE OF BIRTH______________

POLICY HOLDER'S SSN OR ID#________________________ RELATIONSHIP TO PATIENT______________

EMPLOYER OR GROUP NAME_________________________________ GROUP #________________

NAME OF INSURANCE PLAN____

ADDRESS:____PH#________________

SECONDARY INSURANCE INFORMATION

POLICY HOLDER'S NAME___________________________________DATE OF BIRTH______________

POLICY HOLDER'S SSN OR ID#______________________RELATIONSHIP TO PATIENT ______________

EMPLOYER OR GROUP NAME_________________________________ GROUP#__________________

NAME OF INSURANCE PLAN____

CARING FOR YOU........

NAME____DATE_____________________

1) We would like to get to know you better. Would you mind telling us a little about yourself? (FAMILY, FREE TIME, PROFESSION, ETC...)

2) **LONG TERM,** I would like my teeth to be in the following condition:

3) If you could change anything about your smile or teeth, what would that be?

4) What concerns do you have about your dental health, that you would you like us to be aware of?

5) Has anyone mentioned that you occasionally snore?

6) Do you have concerns that might keep you from getting your teeth/smile exactly the way you would want?

   (Please, circle & explain if any of the following examples apply)

   Time:

   Anxiety /Discomfort:

   Cost:

7. In our practice we strive to help you achieve your best dental health and a beautiful smile. Together we hope to move forward in discussing an optimum plan to help you achieve your dental goals.

Is this something you would be interested in discussing with us?

CONSENT, RELEASE, ASSIGNMENT AND FINANCIAL AGREEMENT

PERSONAL CONSENT AND RELEASE

I HEARBY AUTHORIZE AND CONSENT TO THE MAKING OF VIDEOS, PHOTOGRAPHS AND X-RAYS OF MY DENTAL CASE BEFORE, DURING AND AFTER TREATMENT TO BE USED BY THE DOCTOR IN SCIENTIFIC PAPERS OR DEMONSTRATIONS. I UNDERSTAND THAT MY NAME OR ANY OTHER IDENTIFYING INFORMATION WILL NOT BE USED FOR THESE PURPOSES.

ASSIGNMENT

I AUTHORIZE THE OFFICE OF SCOTT A. YOUNG, D.D.S. TO PROVIDE ALL TREATMENT AND SUPPORTING RECORD DOCUMENTATION INFORMATION TO MY INSURANCE CARRIERS AND HEARBY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

FINANCIAL AGREEMENT

I UNDERSTAND THAT PAYMENT IN FULL OR ESTIMATED INSURANCE CO-PAYMENTS ARE EXPECTED PAID AT THE TIME SERVICES ARE RENDERED. I ALSO UNDERSTAND THAT THERE MAY BE UNFORESEEN CIRCUMSTANCES IN WHICH MY INSURANCE MAY NOT COVER ANY OR ALL OF MY CLAIM FOR SERVICES RENDERED.

FOR AND IN CONSIDERATION OF SERVICES RENDERED AND THE POSSIBILITIES OF PARTIAL OR NON-PAYMENT BY MY INSURANCE COVERAGE, I HEARBY AGREE TO GUARANTEE PAYMENT OF ALL CHARGES INCURRED. I ALSO UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN MY ACCOUNT BEING REFERRED TO A COLLECTION AGENCY OR AN ATTORNEY FOR RESOLUTION.

*SIGNATURE OF RESPONSIBLE PARTY*________________________________ *DATE*________

*PRINT NAME*____

*Witness*____________________________________ *DATE*___________

NOTICE OF PRIVACY PRACTICES

PATIENT NAME ____ **DATE OF BIRTH:** ____________

The Dental Office of **Scott A. Young, DDS** at 7810 Ballantyne Commons Pkwy., Suite 105 CHARLOTTE, NC 28227 has a Legal Duty to keep **Protected Health Information** private and to give you this notice describing our legal duties, Privacy Practices and your rights regarding your protected health information. To follow the terms of the current notice and to notify you in a timely manner of an accidental disclosure of your private health information.

OUR USE AND DISCLOSURE OF YOUR PRIVATE HEALTH INFORMATION (PHI)

With your permission we may, as necessary disclose the following types of PHI for the purposes of medical or dental treatment: shared health history, results of tests, x-rays, diagnosis or course of treatment, dates and times of appointments, fees and insurance information, co-payments, or account balances for claims submission or collection efforts to the following persons or entities:

AUTHORIZATION TO RELEASE INFORMATION

PLEASE INDICATE WITH YOUR ***INITIALS***, EACH PERSON/ENTITY AUTHORIZED TO RECEIVE INFORMATION PERTAINING TO YOUR TREATMENT IN OUR OFFICE.

______Medical or Dental Providers involved in your healthcare.
______Spouse, Parent, Guardian, Emergency Contact, OR Other______________________
______Medical or Dental Insurance Companies
______ Third Party Payors Such as Care Credit or a Collection Agency.

Patient Rights:

I understand that I have the right to revoke this authorization at any time by sending a written notification and that a revocation is not effective in cases where the information has already been disclosed but with be in effect going forward. I understand I have the right to inspect or receive a copy of my protected health information used or disclosed as described in this document with a written request to the address or email listed above.

Send all requests to: **Scott A. Young, D.D.S. Attention: HIPAA Officer 7810 Ballantyne Commons Pkwy. Suite 105 Charlotte, NC 28277 or Email to: scottayoungdds@gmail.com.**

Patient Acknowledgement:

I understand that my Protected Health Information is used or disclosed to carry out treatment, payment or health care operations. I also understand that I have the right to refuse to sign this authorization.

Signature Of Patient or Personal Representative:________________________________**Date:**_______

Print Name:____