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.**

Clostridium Difficile (C. diff.)

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:

ARE YOU TAKING ANY GLP-1 drugs for Diabetes or Weight Loss? ___ YES ___ NO
If so circle - Ozempic, Wegovy, Mounjaro, Zephound, Trulicity, Victoza, Rybelsus, Saxenda, other

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	VAPE Smoke: cigarettes/cigars 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.

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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.