

WELCOME TO PACIFIC FAMILY DENTAL CENTER

Mayer Yashar, D.D.S.

12800 Bothell-Everett Highway, Suite 250
Everett, WA 98208
Telephone: (425) 316-5410

Please Print

Date _____ Home Phone _____ Work Phone _____ Cell Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial
Address _____ Email Address: _____
City _____ State _____ Zip _____ Driver's License or I.D.# _____
Sex M F Age _____ Birth Date _____ Single Married
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
How did you hear about our office? _____
Name of nearest relative or friend not living with you _____ Phone _____ Relation _____
Person Responsible for Account _____
Last Name First Name Initial

PRIMARY INSURANCE

Subscriber Name _____ Relation to Patient _____ Birth Date _____ Soc. Sec. # _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____ Insurance Phone # _____
Group # _____ Subscriber # _____ Dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Relation to Patient _____ Birth Date _____ Soc. Sec. # _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Occupation _____
Insurance Company _____ Insurance Phone # _____
Group # _____ Subscriber # _____ Dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have dental insurance and assign directly to Dr. Yashar all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges, whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

I give permission for the doctor or his staff to use photos he may take to be used for lecturing, publishing, or educational purposes.

Signature

Date

MEDICAL HISTORY

Patient Name _____ Birth Date _____ Age _____
Last Name First Name Initial

Are you under the care of a physician? YES NO

Physician Name _____ Phone _____

Name of Previous Dentist _____ Phone _____

In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. **HAVE YOU EVER HAD OR DO YOU HAVE:**

YES NO

		Are you allergic or have you ever reacted adversely to any medication? List:
		Have you ever had a reaction to any local anesthetics?
		Are you taking any medication? List medications:
		Chemical Dependency If yes, what to?
		Do you smoke? If yes, how many cigarettes per day?
		Do you chew tobacco? If yes, frequency:
		WOMEN: Are you pregnant?
		WOMEN: Are you taking birth control pills?
		If Patient is a Child: Child's Height and Weight:
		AIDS or HIV Positive
		Arthritis or Rheumatism
		Back Problems
		High Blood Pressure
		Heart Problems
		Rheumatic Fever or Heart Murmur
		Pace Maker or Open Heart Surgery
		Shortness of Breath
		Bleeding or clotting disorders
		Hepatitis or Jaundice
		Any artificial joints or heart valves
		Cancer
		Diabetes
		Glaucoma
		Liver or Kidney Disease
		Asthma or Other Lung Problems
		Epilepsy or Fainting
		Anxiety or Depression
		Headaches or Earaches
		Thyroid Problems
		Ulcer or Stomach Problems
		Venereal Disease
Any other medical problems or concerns:		

Patient Name _____ Today's Date _____
 Last Name First Name Initial

YES NO

DENTAL HISTORY		
<input type="checkbox"/>	When was your last dental treatment?	Date: _____
<input type="checkbox"/>	When was your last set of full-mouth x-rays?	Date: _____
<input type="checkbox"/>	Do you have any history of injury to jaw or face?	
<input type="checkbox"/>	Do you have any pain or clicking of jaw joint?	
<input type="checkbox"/>	Do you clench or grind your teeth?	
<input type="checkbox"/>	Do you have any numbness in jaw or face?	
<input type="checkbox"/>	Do you have a history of mouth odor?	
<input type="checkbox"/>	Do you have a history of bleeding gums?	
<input type="checkbox"/>	Do you have a history of gum disease?	
<input type="checkbox"/>	Do you have any sensitivity to hot and cold?	
<input type="checkbox"/>	Do you have any sensitivity to sweets?	
<input type="checkbox"/>	Do you have any sharp pain or sensitivity when biting?	
<input type="checkbox"/>	Do you have any sores or growths in mouth?	
<input type="checkbox"/>	Do you have any loose teeth, broken teeth, or broken fillings?	

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

MEDICAL HISTORY UPDATE		
Update:	Date:	Initial:
Update:	Date:	Initial:
Update:	Date:	Initial:
Update:	Date:	Initial:
Update:	Date:	Initial:

Please Tell Us About You...

The better we understand you, the better we can serve you. We would appreciate your taking a few minutes to help us learn more about you. Please make a check mark below to indicate your opinion or preference.

Your Name: _____

- | | |
|---|---|
| <input type="checkbox"/> I know a great deal about my dental condition. | <input type="checkbox"/> I know very little about my dental condition. |
| <input type="checkbox"/> I like to be presented with fewer options. | <input type="checkbox"/> I like to be presented with more options. |
| <input type="checkbox"/> I tend to look at the details. | <input type="checkbox"/> I tend to look at the big picture. |
| <input type="checkbox"/> I prefer long-lasting solutions which may cost more. | <input type="checkbox"/> I prefer more temporary solutions at lower cost. |
| <input type="checkbox"/> I prefer to talk in technical terms with my dentist. | <input type="checkbox"/> I prefer to talk in non-technical terms. |
| <input type="checkbox"/> My insurance largely determines the extent of my care. | <input type="checkbox"/> I largely determine the extent of my care. |
| <input type="checkbox"/> I prefer to wait until I must act. | <input type="checkbox"/> I usually see no reason to delay care. |
| <input type="checkbox"/> I rely more on self-maintenance. | <input type="checkbox"/> I rely more on professional maintenance. |
| <input type="checkbox"/> I like newer and more modern techniques. | <input type="checkbox"/> I prefer tried and true methods. |
| <input type="checkbox"/> I favor a treatment-oriented approach to disease.
(I just want it fixed.) | <input type="checkbox"/> I favor a cause-oriented approach to disease.
(I want to understand the root of the problem.) |

Is there anything in particular that you would like us to know about you or your oral health?

Is there anything in particular that we can do to help you be more comfortable in our office?

APPOINTMENT POLICY

A scheduled appointment is a commitment of time between the Doctor and patient. We have reserved a set amount of time just for you. When appointments are missed or cancelled, that time is lost.

We ask that when you appoint for treatment, you make every effort to keep that appointment. We understand that emergencies do arise, and we will take that into consideration. If you find that you cannot keep your scheduled appointment, our required 48-hour notice allows us to see another patient in need of treatment.

It is a policy of our office that missing appointments without a minimum of 48 hours notice will result in a charge being considered and applied to your account.

Thank you for your consideration and cooperation.

Mayer Yashar, D.D.S.

I have read and understand this policy.

Signed _____

Date _____