We would like to extend a warm welcome to Yenzer Family Dental. We are a full service general and cosmetic dental practice. Yenzer Family Dental offers a wide array of services ranging from Basic Exams, Cleanings, Invisalign, and Smile Make Overs. Dr. Yenzer strives to provide excellent clinical care as well as an unparalleled level of customer service. While we do accept certain insurance plans, we do not allow insurance to dictate treatment. In this office, your best interest and health is the interest we will consider. We look forward to providing you with excellent dental care for many years to come

Patient Information

Mr. Mrs. /Ms. Name: _____

Preferred Name_____

Birthdate: _____ ____Male ____Female

Soc. Sec. #:_____

Address_____

City:_____ State: _____ Zip:_____

Home Phone: _____

Cell/ Other: _____

Email_____

In the event of emergency, who should we contact?

(Name &Number):_____

How did you hear about us?

Name: _____

Do you prefer appointment reminders?

By ___home ___cell___ text or ___email?

Please Check One

Insurance Information

Primary Dental Insurance Company_____

Primary Subscriber Name: _____

Subscriber ID / Soc. Sec. #_____

Subscriber Date of birth: _____

Group Number: _____

Insured's Employer: _____

Insurance Co. Telephone number: _____

Insurance Claim Address: _____

Do you have secondary insurance? ☐ Yes ☐ No

Secondary Insurance _____

Secondary Subscriber Name_____

Secondary Subscriber ID/Soc. Sec. #_____

Secondary subscriber Date of Birth: _____

Group Number: _____

Secondary Insured's Employer: _____

Insurance Co. Telephone Number: _____

Insurance Claim Address: _____

At Yenzer Family Dental, We realize how important insurance benefits are. We ask that *YOU* carefully review your policy and/or contact your insurance carrier, so that *YOU* are aware of benefits frequencies, limitations and /or restrictions. Please be informed that YOUR dental insurance is a contract between YOU and YOUR insurance company. *Our role is to simply assist you with filling your claims*. While we will obtain a summary of benefits from your insurance it is up to you to know the frequencies, limitation and/ or restrictions of your plan. It is your responsibility to provide us with any changes in your insurance. If any dental services have been provided to you by other providers within the existing benefit year, please advise us. Any portion of treatment that your dental insurance does not pay will be your responsibility.

Dental Health

Please provide information on the last dentist you have seen:

Name_____

Phone Number ( ) _____

Date Range seen: _____

Types of treatment: _____

What is the primary reason you came to our office today?_____

_____

Are you currently experiencing any pain/discomfort? ☐ Yes ☐ No

Current Dental Health: ☐ Good ☐ Fair ☐ Poor

Are you happy with your smile? ☐ Yes ☐ No If no please explain:_____

Are your teeth somewhat yellowed, darkened or stained? ☐ Yes ☐ No

Any unpleaseant experiences in a dental Office? ☐ Yes ☐ No

Does food catch between your teeth? ☐ Yes ☐ No

Are your teeth sensitive to cold or sweets? ☐ Yes ☐ No

Have you ever experienced pain or discomfort in your jaw joint? ☐ Yes ☐ No

Are there spaces between any of your teeth? ☐ Yes ☐ No

Do you grind your teeth? Are your teeth chipped or worn down? ☐ Yes ☐ No

Do you have a "gummy" smile –showing too much gum tissue or having gums that are too thick? ☐ Yes ☐ No

Are your gums red, puffy or do they bleed? ☐ Yes ☐ No

Do you have any gray, black, or silver dental fillings in your teeth that you want to replace? ☐ Yes ☐ No

Do you have any old crowns that have dark edges at the top that don't really look natural? ☐ Yes ☐ No

Do you smoke? How much/ often?_____

Do you use smokeless tobacco? How much/ often?_____

Do you drink alcohol? How much/ often?_____

Medical History

Are you allergic to any of the following? If so, Please Circle

Aspirin	Latex	Sulfites
Codeine	Penicillin	Any Metals
Dental Anesthetics	Tetracycline	Erythromycin

Have you ever taken any of the following?

☐ Coumadin ☐ Cortico-Steroids ☐ Zometa

☐ Vioxx ☐ Actonel

☐ Fosamax ☐ Boniva

If Yes, last Date taken_____

Have you ever had any of the following illnesses or medical problems in the past? Please check yes or no

Abnormal Bleeding	Yes____ No____	Gingivitis	Yes____ No____
Alcohol / Drug Abuse	Yes____ No____	Periodontal Disease	Yes____ No____
Allergies	Yes____ No____	Glaucoma	Yes____ No____
Anemia	Yes____ No____	Headaches	Yes____ No____
Artificial Bones/Joints/Valves	Yes____ No____	Heart Attack	Yes____ No____
Asthma	Yes____ No____	**Heart Murmur**	Yes____ No____
Blood Transfusion	Yes____ No____	Heart Surgery	Yes____ No____
Bone/Joint Disease	Yes____ No____	Hepatitis, if yes what Type___	Yes____ No____
Cancer /Chemotherapy	Yes____ No____	Herpes/Fever Blisters	Yes____ No____
Congenital Heart Defect	Yes____ No____	High Blood Pressure	Yes____ No____
Diabetes, if yes A1C_____	Yes____ No____	HIV + / AIDS	Yes____ No____
Difficulty Breathing	Yes____ No____	Jaw pain/TMJ	Yes____ No____
Eating Disorder	Yes____ No____	Kidney Problem	Yes____ No____
Hemophilia	Yes____ No____	Liver Disease	Yes____ No____
Emphysema	Yes____ No____	Low Blood pressure	Yes____ No____
Epilepsy	Yes____ No____	Lupus	Yes____ No____
Fainting Spells	Yes____ No____	**Mitral Valve Prolapse**	Yes____ No____
Nervous Disorder	Yes____ No____	Sinus problems	Yes____ No____
Pacemaker/ICD	Yes____ No____	Spasms/Cramps	Yes____ No____
Psychiatric Care	Yes____ No____	Stroke	Yes____ No____
Radiation Treatment	Yes____ No____	Thyroid Problem	Yes____ No____
Rashes	Yes____ No____	Tuberculosis	Yes____ No____
Rheumatic / Scarlet Fever	Yes____ No____	Tumors	Yes____ No____
Seizures	Yes____ No____	Ulcers	Yes____ No____
Sexually transmitted Disease	Yes____ No____	Other	Yes____ No____
Shingles	Yes____ No____	**Please List**_____	

Do you consider your current overall physical health to be ☐ Good ☐ Fair ☐ Poor

Are you currently under the active care of a physician or do you have any present Health issues? ☐ Yes ☐ No

If yes, Please explain: _____

Do you need to be pre-medicated with antibodies for any heart or other medical conditions prior to dental treatment? ☐ Yes ☐ No

Are you taking any prescriptions or over-the-counter medication? (Including Ibuprofen, diet supplements, etc.) ☐ Yes ☐ No

Please list each one: _____

Are you pregnant or nursing? ☐ Yes ☐ No

If pregnant, which trimester? ☐ 1st ☐ 2nd ☐ 3rd and Due Date_____

Signature_____ Date _____

INFORMATION ABOUT YOUR DENTAL TREATMENT…

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The purpose of the following sections are to inform you of the dental procedures that we routinely perform here, to emphasize the importance of your role and cooperation in achieving a high level of oral health and beauty and to point out the potential risk and inconveniences that may be encountered before, during and after treatment. Your dental treatment may involve one or a combination of the following procedures that are summarized below.

DESCRIPTIONS OF CERTAIN DENTAL PROCEDURES..

Examination & Hygiene Cleanings: the initial examination and hygienic cleaning are intended in part to evaluate and make recommendations regarding the health and appearance of your teeth and gums. The dental exam, hygienic cleaning and any basic restorative (i.e. fillings) or gingival therapy may involve the touching, scaling or periodontal probing of your teeth and oral tissues. Other or subsequent hygienic procedures (periodontal scaling, root planing. etc.) May be indicated and preformed as well depending on your condition. These procedures are designed to remove plaque and calculus from your teeth and help maintain or restore the health of your gums

Fillings or bonding are terms that are commonly used to refer to the placement of composite resin or other appropriate materials in cavities or on teeth. Bonding can also be used to fix broken or chipped tooth surfaces. It can also be used to close spaces between teeth. We do not place amalgam (sometimes called silver or Mercury fillings) in our office we believe there are more desirable restorative materials such as tooth colored composites and porcelain. Although some people have had amalgam fillings for many of years, we can remove the amalgam fillings as they begin to break down or we can remove them per your request and replace them with more desirable restorative material.

Crowns or veneers and other porcelain restorations in enhancements are designed to be life -like looking tooth restorations made out of porcelain or porcelain plus other materials. A crown usually covers the entire tooth structure (although there are 3/4 crowns and other variations that do not cover the entire tooth structure.)Typically more tooth structure is removed to prepare for a crown placement than a veneer (which may entail zero minimal or significant tooth reduction depending on the circumstances)Crowns may be recommended for teeth requiring additional support due to the loss of healthy tooth structure. Veneers primarily cover the front of the teeth, although some varieties have porcelain on the backside of the teeth. While the porcelain enhancements are being fabricated, you will have temporary crowns or veneers, which are not intended to be permanent and are easier to remove or pop off.

A bridge is a replacement made for missing teeth usually composed of porcelain or porcelain fused to a harder substance which is bonded to adjacent teeth. These abutment teeth may require some reduction or crowning in order to support the teeth being replaced.

Root canal therapy can be indicated anytime a tooth receives trauma, decay, dental work performed on it, or for no reason at all. In general the more trauma or amount of work, the higher the risk a root canal will be needed. This therapy consist of removing the damaged or infected nerve in the tooth and replacing it with a sterile material. If there are existing restorations in place this procedure can many times be performed without destroying the restoration, although destruction of the existing restoration is a risk as well. Yenzer family dental attempts to predict and notify you in advance of the likelihood of a root canal therapy depending on your procedure; however all people are different and the human body can react in a myriad of unpredictable ways. Thus, it is impossible to always make accurate predictions of this sort in the vast majority of cases. Therefore, regardless of cause, should you require subsequent root canal therapy or restorative work (whether obtained here or at another office) which has not been paid for as part of your treatment plan, you agree to be responsible for these cost. Even in the best scenario, under ideal conditions 5% of all root canal treated teeth will not last the duration of your life. Any treatment needed above and beyond root canal therapy (i.e. tooth extraction, implants or bridge), is also your responsibility.