York County Pediatric Dentistry

www.yorkcountypediatricdentistry.com
info@ycpd.us
5 Webhannet Place | Suite 1 • Kennebunk, ME 04043
(207)985-2800

UPDATE

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ ____-____
City State Zip Code

Employer Name:

_____

_____

Primary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Do you have Mainecare Insurance? * ◯ Yes ◯ No

If so, what is your Mainecare ID #? _____

Secondary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Medical Information

Indicate which of the following conditions you have or have had. By checking a box you will indicate a "YES" response, leaving blank will indicate a "NO" response

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Abuse	☐ ADHD	☐ Allergy - Aspirin
☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Seasonal	☐ Allergy - Latex	☐ Allergy - Penicillin	☐ Allergy - Sulfa
☐ Allergy - Amox	☐ Allergy - Other	☐ Anemia	☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Autism	☐ Bleeding Disorder	☐ Blind	☐ Blood Disease	☐ Cancer	☐ Cerebral Palsy
☐ Developmental Delay	☐ Diabetes	☐ Dizziness	☐ Down Syndrome	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting	☐ Fever Syndrome	☐ Glaucoma	☐ Head Injuries	☐ Hearing Problems	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ HIV	☐ Immune Deficiency	☐ Jaundice
☐ Kidney Disease	☐ Learning Disability	☐ Liver Disease	☐ Mental Disorders	☐ MS	☐ Nervous Disorders
☐ OCD	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ Sensory Disorder
☐ Sinus Problems	☐ Stomach Problems	☐ Stroke	☐ Thyroid Problems	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Other				

Name of Physician: _____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

If there have been any medical changes since your last visit with us, please list below.

_____

_____

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

☐ ***I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Response Date: _____