Eric Yaremko DMD, P.S.
"Dentistry with Care"

360.734.6620
520 Lakeway Dr, Ste A • Bellingham
EricYaremkoDMD.com

# Dental History

Name _____ Nickname _____ Age _____

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) _____ / _____ / _____

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

**WHAT IS YOUR IMMEDIATE CONCERN?**_____

## Personal History

| | | Yes | No |
|---|---|---|---|
| 1. | Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)?_____ | ☐ | ☐ |
| 2. | Have you had an unfavorable dental experience?_____ | ☐ | ☐ |
| 3. | Have you ever had complications from past dental treatment?_____ | ☐ | ☐ |
| 4. | Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ | ☐ | ☐ |
| 5. | Did you ever have braces, orthodontic treatment, or a bite adjustment?_____ | ☐ | ☐ |
| 6. | Have you had any teeth removed?_____ | ☐ | ☐ |

## Gum and Bone

| | | | |
|---|---|---|---|
| 7. | Do your gums bleed or are they painful when brushing or flossing?_____ | ☐ | ☐ |
| 8. | Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____ | ☐ | ☐ |
| 9. | Have you ever noticed an unpleasant taste or odor in your mouth?_____ | ☐ | ☐ |
| 10. | Is there anyone with a history of periodontal disease in your family?_____ | ☐ | ☐ |
| 11. | Have you ever experienced gum recession?_____ | ☐ | ☐ |
| 12. | Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?____ | ☐ | ☐ |
| 13. | Have you experienced a burning sensation in your mouth?_____ | ☐ | ☐ |

## Tooth Structure

| | | | |
|---|---|---|---|
| 14. | Have you had any cavities within the past 3 years?_____ | ☐ | ☐ |
| 15. | Does the amount of saliva in your mouth seem too small or do you have difficulty swallowing food?_____ | ☐ | ☐ |
| 16. | Do you feel or notice any holes (e.g., pitting, craters) on the biting surface of your teeth?_____ | ☐ | ☐ |
| 17. | Are any teeth sensitive to hot, cold, biting, or sweets, or do you avoid brushing any part of your mouth?_____ | ☐ | ☐ |
| 18. | Do you have grooves or notches on your teeth near the gum line?_____ | ☐ | ☐ |
| 19. | Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____ | ☐ | ☐ |
| 20. | Do you frequently get food caught between any teeth?_____ | ☐ | ☐ |

Eric Yaremko DMD, P.S.
"Dentistry with Care"

360.734.6620
520 Lakeway Dr, Ste A • Bellingham
EricYaremkoDMD.com

## Bite and Jaw Joint

| | Yes | No |
|---|---|---|
| 21. Do you have problems with your jaw joint? (e.g., pain, sounds, limited opening, locking, popping) | ☐ | ☐ |
| 22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? | ☐ | ☐ |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? | ☐ | ☐ |
| 24. Have your teeth changed in the last 5 years (become shorter, thinner, or worn)? | ☐ | ☐ |
| 25. Are your teeth crowding or developing spaces? | ☐ | ☐ |
| 26. Do you have more than one bite and squeeze to make your teeth fit together? | ☐ | ☐ |
| 27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? | ☐ | ☐ |
| 28. Do you clench your teeth in the daytime or make them sore? | ☐ | ☐ |
| 29. Do you have any problems with sleep or wake up with an awareness of your teeth? | ☐ | ☐ |
| 30. Do you wear or have you ever worn a bite appliance? | ☐ | ☐ |

## Smile Characteristics

| | | |
|---|---|---|
| 31. Is there anything about the appearance of your teeth that you would like to change? | ☐ | ☐ |
| 32. Have you ever whitened (bleached) your teeth? | ☐ | ☐ |
| 33. Have you felt uncomfortable or self-conscious about the appearance of your teeth? | ☐ | ☐ |
| 34. Have you been disappointed with the appearance of previous dental work? | ☐ | ☐ |

Patient's signature _____ Date _____

Doctor's signature _____ Date _____

Eric Yaremko DMD, P.S.
"Dentistry with Care"

360.734.6620
520 Lakeway Dr, Ste A • Bellingham
EricYaremkoDMD.com

# 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 | | |
| ☐ Aspirin, ibuprofen, acetaminophen, codeine | | |
| ☐ Penicillin | | |
| ☐ Erythromycin | | |
| ☐ Tetracycline | | |
| ☐ Sulfa | | |
| ☐ 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 _____ | ☐ | ☐ |
| 5. Artificial heart valve, repaired heart defect (PFO) _____ | ☐ | ☐ |
| 6. Pacemaker or implantable defibrillator _____ | ☐ | ☐ |
| 7. Artificial prosthesis (heart valve or joints) _____ | ☐ | ☐ |
| 8. Rheumatic or scarlet fever _____ | ☐ | ☐ |
| 9. High or low blood pressure _____ | ☐ | ☐ |
| 10. A stroke (taking blood thinners) _____ | ☐ | ☐ |
| 11. Anemia or other blood disorder _____ | ☐ | ☐ |
| 12. Prolonged bleeding due to a slight cut (INR > 3.5) _____ | ☐ | ☐ |
| 13. Emphysema, shortness of breath, sarcoidosis _____ | ☐ | ☐ |
| 14. Tuberculosis, measles, chickenpox _____ | ☐ | ☐ |
| 15. Asthma _____ | ☐ | ☐ |
| 16. Breathing/sleep problems (e.g., sleep apnea, snoring, sinus) | ☐ | ☐ |
| 17. Kidney disease _____ | ☐ | ☐ |
| 18. Liver disease _____ | ☐ | ☐ |
| 19. Jaundice _____ | ☐ | ☐ |
| 20. Thyroid or parathyroid disease, or calcium deficiency _____ | ☐ | ☐ |
| 21. Hormone deficiency _____ | ☐ | ☐ |
| 22. High cholesterol or taking statin drugs _____ | ☐ | ☐ |
| 23. Diabetes (HbA1c = _____ ) _____ | ☐ | ☐ |
| 24. Stomach or duodenal ulcer _____ | ☐ | ☐ |
| 25. Digestive disorders (e.g., celiac disease, gastric reflux) _____ | ☐ | ☐ |
| 26. Osteoporosis/osteopenia (i.e., taking bisphosphonates) _____ | ☐ | ☐ |
| 27. Arthritis, rheumatoid arthritis, lupus _____ | ☐ | ☐ |
| 28. Glaucoma _____ | ☐ | ☐ |
| 29. Contact lenses _____ | ☐ | ☐ |
| 30. Head or neck injuries _____ | ☐ | ☐ |
| 31. Epilepsy, convulsions (seizures) _____ | ☐ | ☐ |
| 32. Neurologic disorders (e.g., ADD/ADHD, prion disease) _____ | ☐ | ☐ |
| 33. Viral infections and cold sores _____ | ☐ | ☐ |
| 34. Any lumps or swelling in the mouth _____ | ☐ | ☐ |
| 35. Hives, skin rash, hay fever _____ | ☐ | ☐ |
| 36. STI/STD _____ | ☐ | ☐ |
| 37. Hepatitis (type ___ ) _____ | ☐ | ☐ |
| 38. HIV/AIDS _____ | ☐ | ☐ |
| 39. Tumor, abnormal growth _____ | ☐ | ☐ |
| 40. Radiation therapy _____ | ☐ | ☐ |
| 41. Chemotherapy, immunosuppressive _____ | ☐ | ☐ |
| 42. Emotional problems _____ | ☐ | ☐ |
| 43. Psychiatric treatment _____ | ☐ | ☐ |
| 44. Antidepressant medication _____ | ☐ | ☐ |
| 45. Alcohol/street drug use _____ | ☐ | ☐ |
| **ARE YOU:** | | |
| 46. Presently being treated for any other illness _____ | ☐ | ☐ |
| 47. Aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, diarrhea) _____ | ☐ | ☐ |
| 48. Taking medication for weight management (e.g., fen-phen) | ☐ | ☐ |
| 49. Taking dietary supplements _____ | ☐ | ☐ |
| 50. Often exhausted or fatigued _____ | ☐ | ☐ |
| 51. Experiencing frequent headaches _____ | ☐ | ☐ |
| 52. A smoker, smoked previously, or use smokeless tobacco ____ | ☐ | ☐ |
| 53. Considered a touchy person _____ | ☐ | ☐ |
| 54. Often unhappy or depressed _____ | ☐ | ☐ |
| 55. FEMALE - taking birth control pills _____ | ☐ | ☐ |
| 56. FEMALE - pregnant _____ | ☐ | ☐ |
| 57. MALE - suffering a prostate disorder _____ | ☐ | ☐ |

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (e.g., Botox, collagen injections).

_____

List all medications, supplements, and or vitamins taken within the last two years (ask for an additional sheet if taking more than six)

| Drug | Purpose | Drug | Purpose |
|---|---|---|---|
| | | | |
| | | | |

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Eric Yaremko DMD, P.S.
*"Dentistry with Care"*

# Confidential Information Questionnaire

Patient's name _____ Date of birth _____
Last First Middle

Address _____
Mailing address Apt # City State Zip

Phone _____ Cell _____ Email _____

Social security number _____ Sex Female Marital status Single

Employer _____ Occupation _____

Employer address _____ Work phone _____

*Person responsible for this account _____ Relationship _____

Spouse or parent name _____
Last First Middle Relationship

Spouse/parent employer _____ Occupation _____

Employer's address _____ Phone _____

Emergency person we can contact _____ Phone _____

Names of other family members who are patients here _____

**Whom may we thank for referring you to our office?** Please check all that apply.

Family member ☐ Friend (name) ☐ Radio ☐ Phone book ☐ Website ☐

Did you choose our office because of: Our reputation ☐ Our ability to care for high-anxiety patients ☐
Our location ☐ Other _____

**Insurance Information**
Do you have dental insurance? Yes ☐ No ☐ Name and address of subscriber _____

Subscriber's SS# or ID# _____ Subscriber's DOB _____

Insurance company _____ Group# _____ Phone _____

Mailing address for claims _____

Do you have secondary dental insurance? Yes ☐ No ☐ Name of subscriber _____

Subscriber's SS# or ID# _____ Subscriber's DOB _____

Insurance company _____ Group# _____ Phone _____

Insurance mailing address _____

**Assignment and Release**
I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due and authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy. Please refer to our written Financial Policy.

I consent to the taking of photographs and X-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers and demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature _____ Date _____

Eric Yaremko DMD, P.S.
"Dentistry with Care"

# Financial Policy

**As a patient with dental insurance, you are ultimately responsible to know and understand your dental coverage.** We will gladly submit your dental charges to your insurance company for you. If we are unable to collect from your insurance company within 90 days, the amount expected from them will become your responsibility. We make every effort to calculate the estimated copayment you will have for each procedure. This will be reviewed with you prior to treatment and due at time of service. **We can only track the amount of insurance dollars used in our office. If you are seen at any other office, you need to calculate that into any estimates we give you.**

**As a cash patient,** your estimated cost of procedures will always be reviewed by us prior to treatment, and this amount will be due at the time of treatment. To make this convenient for you, we accept cash, check, Visa, MasterCard, Discover, American Express, and debit cards with Visa or MasterCard logos.

**There will be a fee of $40 per half hour for any missed appointments or appointments canceled with less than 48 hours' notice.**

Because our office is not set up as a loan institution, we cannot carry your account. We ask that you get outside financing for any amount you cannot pay at the time of service. **Please remember that financing must be arranged prior to your treatment.**

Patients having crown or bridge work done must pay their portion at the preparation date of the procedure. If after 120 days from the preparation date the crown or bridge has not been placed due to no fault of Dr. Yaremko, you will be responsible for the entire cost.

**The treatment plan you are given prior to treatment is an estimate only and is valid for 90 days.**

Date _____ Patient Signature _____

Eric Yaremko DMD, P.S.
"Dentistry with Care"

# Insurance Exclusion Disclaimer

Dear Patient:

Our practice is designed to provide excellent, quality care and specific, detailed, individualized treatment. We do not provide discount care.

Be advised that although we accept assignment from almost all insurance companies, we are ***not*** discount providers for any (your insurance company will call this a preferred provider organization or PPO).

I acknowledge that I have been informed that Eric Yaremko DMD does ***not*** participate in any PPO plan.

Signature _____ Date _____

Eric Yaremko DMD, P.S.
"Dentistry with Care"

# Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Eric A. Yaremko, DMD, PS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my statements, payment for services, or in the performance of office heath care operations. The Statement of Privacy Practices also describes my right and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Eric A. Yaremko, DMD, PS, reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

## Additional Disclosure Authorization

*In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) identified below. (I understand that the default answer is "NO." Without indicating "YES" in answer to each individual question, personal protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)*

| | | |
|---|---|---|
| Spouse only | ☐ Yes | ☐ No |
| Any member of my immediate family: (Spouse, Children, Children's Spouses) | ☐ Yes | ☐ No |
| Any member of my extended family: (Parents, Grandchildren) | ☐ Yes | ☐ No |
| Other: _____ | ☐ Yes | ☐ No |

Name of patient (please print): _____

Patient signature: _____

Patient's personal representative (please print): _____

Personal representative's signature: _____

Representative's phone number: _____ Date: _____

**OFFICE USE ONLY BELOW THIS LINE**

### Acknowledgment Not Obtained

Provided Prior to Treatment ☐ Yes ☐ No Date Statement Provided: _____

Reason for not obtaining patient signature:

- ☐ Needed more time to review Statement
- ☐ Wanted to consult another person before signing
- ☐ Physically unable to sign
- ☐ No reason offered
- ☐ Other