Oak Road DENTISTRY

Patient #_____

SSN # _____

Date _____

Patient Information

Name_____ Sex: ☐Male ☐Female Birth-date_____

Address_____ City_____ State_____ Zip_____

☐Single ☐Married ☐Widowed ☐Divorced ☐Minor ☐Separated ☐Partnered for ___ Years

Email_____ Cell Phone(____)_____ Home Phone(____)_____

Employer/School_____ Employer/School Phone(____)_____

Employer/School Address_____ City_____ State_____ Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone(____)_____

Whom may we thank for referring you? _____

Emergency Contact _____ Phone(_____)_____

Responsible Party

Responsible Person for this Account_____ Relation to Patient_____

Address_____ Home Phone(_____)_____

Drivers License #_____ Birth-date_____ Bank_____

Employer_____ Work Phone_____

Currently a Patient at our office? ☐YES ☐NO Email_____ Cell Phone(____)_____

Insurance Information

Name of Insured_____ Relation to Patient_____ Birth-date_____ SSN# _____

Employer_____ Date Employed_____ Work Phone (____)_____

Employer Address_____ City_____ State_____ Zip Code_____

Insurance Company_____ Group#_____ Union or Local#_____

Address_____ City_____ State_____ Zip Code_____

Max Annual Benefit_____ How Much is your Deductible? _____ How much have you used?_____

Additional Insurance

Name of Insured_____ Relation to Patient_____ Birth-date_____ SSN# _____

Employer_____ Date Employed_____ Work Phone (____)_____

Employer Address_____ City_____ State_____ Zip Code_____

Insurance Company_____ Group#_____ Union or Local#_____

Address_____ City_____ State_____ Zip Code_____

Max Annual Benefit_____ How Much is your Deductible? _____ How much have you used?_____

PATIENT'S DENTAL HEALTH

Why have you come to see us today? *(e.g.: pain, checkup, not happy with your smile, etc.)*

_____

_____

Previous Dentist_____ Last Visit _____ **Date of last cleaning** _____

Reasons for changing dentists:

_____

What problems have you had with past dental treatment?

_____

Are you nervous about seeing a dentist? ☐Yes! ☐No Are you interested in Sedation Dentistry? ☐Yes! ☐No

If yes please, tell us why: _____

How often do you brush? _____ Do you floss? ☐ Yes ☐No **How often?** _____

(Please circle each)

Y N I clench or grind my teeth during the day or while sleeping.

Y N I have problems eating.

Y N I avoid brushing part of my mouth due to pain.

Y N My gums bleed while brushing or flossing.

Y N I want my teeth straighter.

Y N I want my teeth whiter.

Y N I have had a facial or jaw injury.

Y N My gums feel tender or swollen.

Y N I would like to improve my smile.

Y N I have had orthodontics.

What are your dental priorities?

_____

(e.g.: appearance, dental health, financial considerations, etc.)

PATIENT'S MEDICAL HISTORY

I consider my health to be (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you had any of the follow? Please circle Y for yes or N for no.

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Pacemaker
7. Y N Stent
8. Y N Abnormal Blood Pressure
9. Y N Anemia
10. Y N Prolonged Bleeding Disorder
11. Y N Tuberculosis or Lung Disease
12. Y N Asthma
13. Y N Hay Fever
14. Y N Sinus Trouble
15. Y N Epilepsy/Seizures
16. Y N Ulcers
25. Y N Liver Disease
26. Y N Jaundice
27. Y N Hepatitis Type _____
28. Y N Diabetes
29. Y N Excessive Urination and/or Thirst
30. Y N Infectious Mononucleosis ("Mono")
31. Y N Herpes
32. Y N Arthritis
33. Y N Sexually Transmitted Diseases
34. Y N Kidney Disease
35. Y N Tumor or Malignancy
36. Y N Cancer/Chemotherapy
37. Y N Radiation/Therapy
38. Y N History of Drug Addiction
39. Y N HIV
40. Y N AIDS
41. Y N Immune Suppressive Disorder
42. Y N Hearing Loss
43. Y N Fainting Spells
44. Y N Glaucoma
45. Y N History of Emotional Disorders

WOMEN:

46. Y N Are you taking birth control medication?
47. Y N Are you pregnant or nursing?

17. Y N Implants/Artificial Joints: Hip-Knee_____ Other _____ What year was it placed?_____
18. Y N I smoke or use chewing tobacco If yes, how much per day? _____ How many years?_____
19. Y N I have consumed alcohol within the last 24 hours.
20. Y N I usually take antibiotic prior to dental treatment
21. Y N Have you ever taken Fen-Phen or Redux?
22. Y N Are you currently or ever taken Bisphosphonates(Fosamax, Boniva, Actonel, Aredia, Zometa,etc.) for Osteoporosis or any other condition?
23. Y N I have had major surgery Year _____ Type of operation_____ Year _____Type of operation _____
24. Y N Do you have any other medical problem or medical history NOT listed on this form?

_____

_____

Are you allergic to any of the following?

48. Y N Aspirin
49. Y N Ibuprofen
50. Y N Sulfa Drugs/Sulfites/Sulfides
51. Y N Penicillin
52. Y N Codeine
53. Y N Latex, Metals, Plastics
54. Y N Local Anesthetics (i.e. Lidocaine, Prilocaine)
55. Y N Other Medications Which ones?

_____

Please list all medications you are currently taking:

_____

_____

_____

_____

_____

Physician's Name _____

Phone _____ Fax_____

Address

_____

_____

How did you hear about our Office?

(check only one)

☐ Referred by a friend ☐ Google (or any online search) ☐ Yelp (OR online review site) ☐ Insurance Plan
☐ Drive by/Signage ☐ Other _____

Who selected this office? ☐Self ☐ Spouse ☐ Parent ☐Employer

If you were referred, whom may we thank for referring you? _____

Authorization & Release

To the best of my knowledge, the above information is complete and accurate. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr._____ 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 authorize the use of my signature on all insurance submissions.

The above named dentist may use health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please PRINT name of Patient, Parent, Guardian or Personal Representative Date