

OAKWELL DENTAL CARE

Big City Convenience, Hometown Care

Welcome to our practice! So that we may provide you with the best possible care, please complete all parts of this dental/medical history form. All information is completely confidential.

Today's Date:_____ PATIENT REGISTRATION Title: Mr. Mrs. Miss Dr. Other: Last Name: _____ First: _____ Middle Initial: ____ Preferred: _____ ______City: ______State: _____Zip: _____ Home Phone: _____ Cell Phone: _____ Work Phone: Ext: ______I prefer to be contacted via (call home, text, e-mail, cell): ______ Birth Date: _____ Age: ___ Social Sec: _____ Drivers Lic: ____ Gender: ____ Marital Status: O Single O Married O Divorced O Widowed O Separated O Child Other family members seen by us: ______ Whom may we thank for referring you? _____ _____ Phone Number: _____ What pharmacy do you usually use: _____ If Child, parent's name: ______ Parents Address, if different: _____ **EMPLOYMENT & SUPPLEMENTAL CONTACT INFORMATION** Address: Employer: Length of Employment: _____ Occupation: ____ Spouse's Name: ______ Spouse's Employer: _____ Work phone: Spouse's SSN: ______ Spouses DOB: _____ Spouse's Drivers Lic #: _____ Emergency Contact: _____ Emergency Contact Phone: _____ Relationship: ____ Neighbor or Relative not living with you: _____ Contact Phone: ____ INSURANCE INFORMATION Dental Coverage: Yes No Orthodontic Coverage: Yes No Medical Coverage: Yes No ______ Phone: ______ Group or Policy #: _____ Insurance Co. Name: _____ State: _____ Zip: _____ City: _____ Insured's SSN: _____ _____ Insured's DOB: ______ Relationship: _____ ___Employers Address: _____

DENTAL HISTORY

Why have you come to the dentist today:								
Yes	No	Are you currently in pain?						
Yes	No	Do you require antibiotics before dental treatment?						
Yes	No	Do you use a bite plate or mouth guard?						
Yes	No	Do you require antibiotics before dental work?						
Yes	No	Have you experience problems associated						
		with any previous dental treatment?						
Yes	No	Do you now or have you ever experienced						
		pain or discomfort in your jaw joint (TMJ)?						
Yes	No	Do you brush daily?						
Yes	No	Do you floss daily?						
Good	Fair	Poor	Which describes your current dental health?					
Hard	Med	Soft	Type of bristles on your toothbrush					
		How long do you use your toothbrush before replacing it						
Yes	No	Do you use anything besides a toothbrush						
		or floss?						
Yes	No	Would you like fresher breath?						
Yes	No	Would you like whiter teeth?						
Yes	No	Do your gums ever bleed?						
Yes	No	Do your gums ever hurt or itch?						
Yes	No	Have you ever had periodontal disease?						
Yes	No	Do you have mobility in your teeth?						
Yes	No	Are your teeth sensitive to hot or cold?						
Anything else?								
Yes	Yes No Do you still have your wisdom teeth?							
If yes, Why?								
Yes	No	Do you clench your teeth at night?						
Yes	No	Have you noticed that your breath has been bad						
		recently?						
Yes	No	Have you	ever had your bite adjusted?					
Yes	No	Do you frequently get cold sores or lesions on your						
		mouth?						

Yes	No	Have you ever had a serious injury to your head								
		or mouth? Explain:								
Yes	No	Do you get a click or pop when you chew?								
Yes	No	Does food tend to get caught between your teeth?								
Yes	No	Is it difficult to chew on either side of your mouth?								
Yes	No	Do you frequently have head, neck or shoulder aches?								
Yes	No	Is it important that you keep your teeth all of your life?								
Yes	No	Do you bite your lips or teeth regularly?								
Yes	No	Are you nervous about having dental treatment?								
Yes	No	Do you hold foreign objects in your mouth?								
		(Pens, bite nails, etc)								
Yes	No	Do you "mouth breath" when awake or asleep?								
Yes	No	Do you snore?								
Yes	No	Do you use more than two pillows to sleep?								
Yes	No	Have you ever had an upsetting dental experience?								
Yes	No	Do you have tire or aching jaws in the morning?								
Yes	No	Do you chew ice?								
Last Dent	ist seen:	Previous Current								
Date of la	st visit:									
Why did y	ou leave yo	our previous dentist?								
What did you like most about your previous dentist?										
What did you like least about your previous dentist?										
Yes No Are you happy with the way your smile looks? If not, what would you change?										
Please include anything else you would like us to know about your dental										

Please include anything else you would like us to know about your dental treatments, that will help make this a good experience and a true partnership between the two of us.

Yes No Do you have a personal physician? Ance you alrefully already in the following? Please entwert each item. Y N Asplan Y N Continue Y N Dental/Netable Y N Continue Y N Dental/Netable Y N Personal Presentation Y N Dental/Netable N Dental/Netable Y N Dental/Netable	MED	OICAL HIS	ГОР	lΥ												
Andress: From # Last visit date	Yes No Do you have a personal physician?						Are y	ou allergic to any	of the	follo	wing? Please answer each it	tem.				
Phone ## Last visit date Y N Latex	Physicians Name:				_		Y 1	I Aspirin			Y N Barbiturates		\top	Y N Codeine		
Good Pair Poor Vour current physical health is: Yes No Are you currently under the care of a physician? Please explain: Yes No Day ou smoke or use bibasco in any form? Yes No Lane you had an increase or loss in wright of more than 20ths in the peat month? MEDICAL CONDITIONS AND MEDICATION SUMMARY We No Are you surrently: MEDICAL CONDITIONS AND MEDICATION SUMMARY N Acetaminophen Y N Blood Pressure Medication Y N InsulinDiabetes Med V N Thyroid Medicine V N Application Y N Application Y N InsulinDiabetes Med V N Thyroid Medicine U N Application Y N Application Y N Recreational Drugs Y N Application Y N Digitals or Heart Meds Y N Recreational Drugs Y N Application Y N Collis Application Y N Recreational Drugs Y N Application Y N Collis Application Y N Recreational Drugs Y N Application Y N Digitals or Heart Meds Y N Recreational Drugs Y N Application Y N Collis Application Y N Recreational Drugs Y N Collis Application Y N Recreational Drugs Y N Other Pendinin? Power than 1 The International Properties of the Season of th	Address: _				_		1 Y	I Dental Anesthe	esia		Y N Erythromycin			Y N Jewelry/Metals		
Other Allergies	Phone #:		Last	visit date:	-		Y 1	I Latex			Y N Penicillin			Y N Sedatives		
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Yes No	Yes	No Are you cu	ırrently u	nder the care of a physician?			Othe	r Allergies:								
Yes No	Please explain:					WOMEN ONLY										
Yes No Nave you had an increase or loss in weight of more than 20tos in the past month?	Yes						Yes No Are you taking birth control pills?									
MEDICAL CONDITIONS AND MEDICATION SUMMARY Y N Acetaminophen Y N Blood Thinners Y N Ibuprofen Y N Steroids Y N Have you taken Phen-Fer? Also Antihistamines Y N Blood Pressure Medication Y N Insulin/Diabetes Medis Y N Thyroid Medicine taken Phen-Fer? Also Norm as Redux or Y N Antihistamines Y N Digitalis or Heart Medis Y N Nitroglycerin Y N Tranquilizers Norm as Redux or Y N Antihistamines Y N Digitalis or Heart Medis Y N Recreational Drugs Y N Other Productions are potentially very dangerous, and the easiest to eliminate as a danger, if you remember to list everything, Please list ALL OTHER prescriptions, over the courter drugs, herbal remedies, vitaminis or minerals not listed above. Do you have, or have you ever experience, any of the following? Y N Abnormal Bleeding Y N Colliss Y N Heart Attack Y N Liver Disease Y N Shingles Y N Anonham Y N Difficulty Breathing Y N Heart Attack Y N Low Blood Pressure Y N Six Ne Problems Y N Anthritis Y N Difficulty Breathing Y N Heart Surgery Y N Mitral Valve Prologose Y N Stroid Therapy Y N Anthritis Y N Difficulty Breathing Y N Heart Surgery Y N Mitral Valve Prologose Y N Stroid Therapy Y N Anthritis Y N Emphysiama Y N Hempshila Y N Persistent Cough Y N Tryorid Problems Y N Asthma Y N Epilepsy Y N Heighest Y N Heighbood Pressure Y N Stroke Y N Cancer Y N Fewer Blatters Y N High Blood Pressure Y N Reduction Treatment Y N Tuberculosis (TB) Y N Cancer Y N Fewer Blatters Y N High Blood Pressure Y N Secret Fewer Y N Uncers Y N Cancer Y N Fewer Blatters Y N High Blood Pressure Y N Secret Fewer Y N Uncers Y N Cancer Y N Fewer Blatters Y N Hospitalized (explain) Y N Scarlet Fewer Y N Uncers Y N Cancer Y N Fewer Blatters Y N Hospitalized (explain) Y N Scarlet Fewer Y N Uncers Y N Chemotherapy Y N Gleucoma Y N Hospitalized (explain) Y N Scarlet Fewer Y N Venereal Disease Feducation of the detail steff to perform the necessary dental services I may need a data or responsible for paying any co-payment and adoutible that my insurance does not cover. I hereby authorize the	Yes	No Have you	ever had	Hepatitis A, B or C?		Yes No Unsure Are you pregnant? If yes, week #										
MEDICAL CONDITIONS AND MEDICATION SUMMARY Y N Acetaminophen Y N Blood Thinners Y N Ibuprofen Y N Steroids Y N Have you taken Phen-Pen? Also Normal Medicine Y N Antibiotics Y N Blood Pressure Medication Y N Imsulin/Diabetes Medis Y N Thyroid Medicine taken Phen-Pen? Also Normal Redux or Y N Antibistamines Y N Cold Remedies Y N Nitroglycerin Y N Tranquilizers Normal Redux or Y N Aspirin Y N Digitalis or Heart Medis Y N Recreational Drugs Y N Other Pondimin? Drug interactions are potentially very dangerous, and the easiest to eliminate as a danger, if you remember to list everything, Please list ALL OTHER prescriptions, over the counter drugs, herbal remedies, vitamins or minerals not listed above. Do you have, or have you ever experience, any of the following? Y N Abnormal Bleeding Y N Colliss Y N Heart Attack Y N Liver Disease Y N Siningles Y N Acchol Abuse Y N Congenital Heart Defect Y N Heart Attack Y N Love Blood Pressure Y N Sinus Problems Y N Arthridis Y N Difficulty Breathing Y N Heart Murmur Y N Lupus Y N Sinus Problems Y N Arthridis Y N Directive Breathing Y N Heart Surgery Y N Mitral Valve Prolapse Y N Stroke Y N Arthridis Valves Y N Emphysema Y N Hepatitis Y N Pacemaker Y N Stroke Y N Asthma Y N Epilepsy Y N Herpatitis Y N Pacemaker Y N Thyroid Problems Y N Asthma Y N Epilepsy Y N Herpatitis Y N Pachisteric Cough Y N Thyroid Problems Y N Cancer Y N Fever Bilisters Y N Hill-ViAIDS Y N Radiation Treatment Y N Tuberculosis (TB) Please clarify any Items marked YES above, and list any serious medical conditions not listed above: I authorize the dental staff to perform the necessary dental services I may need My method of payment will be	Yes	No Have you	had an in	crease or loss in weight of mo	re	Yes No Are you nursing?										
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	Signature Date				_		signature on all my insurance submissions, whether manual or electronic.									

Date

Signature

Our office is HIPAA compliant, and is committed to meeting or exceeding the standards of OSHA, CDC and ADA.