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: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

E-Mail: _____ I prefer to be contacted via (call home, text, e-mail, cell): _____

Birth Date: _____ Age: ____ Social Sec: _____ Drivers Lic: _____ Gender: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated ○ Child

Other family members seen by us: _____ Whom may we thank for referring you? _____

What pharmacy do you usually use: _____ Phone Number: _____

If Child, parent's name: _____ Parents Address, if different: _____

EMPLOYMENT & SUPPLEMENTAL CONTACT INFORMATION

Employer: _____ Address: _____

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

Insurance Co. Name: _____ Phone: _____ Group or Policy #: _____

Insurance Co. Address: _____City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's SSN: _____ Insured's DOB: _____ Relationship: _____

Insured's Employer: _____ 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 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 Dentist seen: _____ Previous Current

Date of last visit: _____

Why did you leave your 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 treatments, that will help make this a good experience and a true partnership between the two of us.

MEDICAL HISTORY

Yes No Do you have a personal physician?

Physicians Name: _____

Address: _____

Phone #: _____ Last visit date: _____

Good Fair Poor Your current physical health is:

Yes No Are you currently under the care of a physician?

Please explain: _____

Yes No Do you smoke or use tobacco in any form?

Yes No Have you ever had Hepatitis A, B or C?

Yes No Have you had an increase or loss in weight of more than 20lbs in the past month?

Are you allergic to any of the following? Please answer each item.

Y N Aspirin	Y N Barbiturates	Y N Codeine
Y N Dental Anesthesia	Y N Erythromycin	Y N Jewelry/Metals
Y N Latex	Y N Penicillin	Y N Sedatives
Y N Sulfa Drugs	Y N Tetracycline	Y N Other (explain)

Other Allergies: _____

WOMEN ONLY

Yes No Are you taking birth control pills?

Yes No Unsure Are you pregnant? If yes, week # _____

Yes No Are you nursing?

MEDICAL CONDITIONS AND MEDICATION SUMMARY

Y N Acetaminophen	Y N Blood Thinners	Y N Ibuprofen	Y N Steroids	Y N Have you taken Phen-Fen? Also known as Redux or Pondimin?
Y N Antibiotics	Y N Blood Pressure Medication	Y N Insulin/Diabetes Meds	Y N Thyroid Medicine	
Y N Antihistamines	Y N Cold Remedies	Y N Nitroglycerin	Y N Tranquilizers	
Y N Aspirin	Y N Digitalis or Heart Meds	Y N Recreational Drugs	Y N Other	

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 Colitis	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial bones/joints	Y N Drug Abuse	Y N Hemophilia	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fever Blisters	Y N HIV+/AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized (explain)	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Seizures	Y N OTHER (EXPLAIN)

Please clarify any items marked YES above, and list any serious medical conditions not listed above: _____

_____

_____

I affirm that the information I have given is correct to the best of my knowledge. This information will be held in the strictest confidence. I realize it is my responsibility to inform Oakwell Dental of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need

My method of payment will be _____

_____ _____

Signature Date

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

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to assure the payment of benefits. Additionally, I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature Date

_____ _____