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 and 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 and Physician Information

Primary Insruance: Medical Coverage: Yes No Dental Coverage: Yes No Orthodontic 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 MEDICATIONS 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. ______________________________

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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: ______________________________

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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

______________________________ ____________