oakgrovedental

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's name ____ Preferred name _________________ Birth date___________

If minor, parents names ______________________________ Home phone _____________ Work phone _____________

Mailing address ____ City ___________________State ________ Zip ___________

Email Address____Alt Email____

Employer ____________________________________ Employer Address____

Employer Phone Number________________________

Spouse's name ________________________________ Spouse's employer _________________________________ ❑ Unmarried

Whom may we thank for referring you to our office? ____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____________________ Dental Insurance Co._______________ Group number___________

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _______________________ Group number __________________

Spouse's birthday ______________________ Social Security number ___________________________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart Failure/Attack/ Angina
- ❑ Heart Murmur, Mitral Valve Prolapse, Heart Defect
- ❑ Rheumatic Fever/ Rheumatic Heart Disease
- ❑ Artificial joint / Valve
- ❑ High / Low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis / Lung problems
- ❑ Kidney disease
- ❑ Hepatitis A, B,or C
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy/ Seizures/ Fainting spells
- ❑ Psychiatric care
- ❑ Herpes/ Cold sores
- ❑ AIDS / HIV positive
- ❑ Migraine headaches/ Frequent headaches
- ❑ Anemia / Blood disorders
- ❑ Abnormal bleeding after extractions, or surgery
- ❑ Hayfever / Sinus trouble
- ❑ Allergies / Hives
- ❑ Asthma
- ❑ Pacemaker/Heart Surgery
- ❑ Drug Addiction or Alcoholism
- ❑ Stroke
- ❑ Stomach/Intestinal Disease
- ❑ Radiation Treatments
- ❑ Thyroid / Parathyroid Disease
- ❑ Pain in Jaw Joints
- ❑ Hypoglycemia
- ❑ Chemotherapy
- ❑ Do you smoke or use chewing tobacco? ❑ yes ❑ no
- ❑ Neck/Head Injury
- ❑ Do you take, or have you taken, Phen-Fen or Redux?
  ❑ yes ❑ no
- ❑ Do you take, or have you taken Biophosphonates?
  ❑ yes ❑ no

Are you taking any prescription drugs, or over the counter drugs?

❑ yes ❑ no If yes, please explain:______________________

____

Are you taking Coumadin/Blood Thinners?
❑ yes ❑ no

Women:
Are you pregnant, or possibly pregnant?
❑ yes ❑ no
Taking oral contraceptives? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex
- ❑ Penicillin, Amoxicillin, Tetracycline
- ❑ Local Anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Hydrcodone/Vicodin
- ❑ Aspirin/Ibuprofen/Tylenol/Advil
- ❑ Other Allergies not Listed?____________________

DENTAL HISTORY

What would you like us to do today?________________________________Any discomfort?____________________

Former Dentist____

Address of Former Dentist______________________________________City______________State__________Zip__________

Have you ever experienced any of the following?

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or Popping Jaw
- ❑ Food Between Teeth
- ❑ Grinding
- ❑ Loose Teeth
- ❑ Sensitivity
- ❑ Other:_________________

Is there anything about your smile that you would like to change?

Please explain:____

Have you ever experienced a problem during dental care?____

Do you premedicate with antibiotics prior to dental appointments?

❑ yes ❑ no If yes, what do you take?______________________

Name of your physician:____

Have you ever been hospitalized or had a major operation? ❑ yes ❑ no If yes, please explain:______________________________

____

Do you have any disease, condition, or problem not listed above?____

Please add anything else you would like us to know about:____

AUTHORIZATION

I hereby consent to allow the Doctors of Oak Grove Dental to obtain adequate information to diagnose my dental health. This may include the production of radiographs, performing diagnostics tests, administering local anesthetics, and communicating with other healthcare providers involved in my treatment.

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. If there is any change in my medical status, I will inform my dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for service rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature______________________________Date______________________________Reviewed By: ______________________

Payment is due in full at the time of treatment, unless prior arrangements have been approved.