29th Street
DENTAL CARE

1 About You

Today's Date: _____

E-mail Address: _____

Last Name: _____

First Name: _____ MI: _____ Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____/_____/_____ Age: _____

SS#: _____

Home Address: _____

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (_____)_____ Cell #: (_____)_____

Wk #: (_____)_____ Ext. _____ DL #: _____

Employer: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Cell #: (_____)_____ SS #: _____

Birthdate: ____/____/____ Driver's License#: _____

Person Responsible for Account: _____

Cell #: (_____)_____ Hm #: (_____)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Insurance Coverage

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Phone #: (_____)_____

Insured's Name: _____

Insured's Birthday: _____ / _____ / _____

Insured's SS #: _____

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Phone #: (_____)_____

Insured's Name: _____

Insured's Birthday: _____ / _____ / _____

Insured's SS #: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____

Relation: _____

Cell #: (_____)_____ Hm #: (_____)_____

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (_____)_____ Date of last visit: _____

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

Please explain: _____

2900 W. Grand Avenue • Chickasha • OK • 73018
405-222-0222

4 Medical History *Continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/ over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one:

_____

_____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-fen? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #:_____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

y N	Abnormal Bleeding	y N	Hepatitis
y N	Alcohol / Drug Abuse	y N	Herpes / Fever Blisters
y N	Anemia	y N	High Blood Pressure
y N	Arthritis	y N	HIV+ / AIDS
y N	Artificial Bones / Joints / Valves	y N	Hospitalized for any reason
y N	Asthma	y N	Kidney Problems
y N	Blood Transfusion	y N	Liver Disease
y N	Cancer / Chemotherapy	y N	Low Blood Pressure
y N	Colitis	y N	Mitral Valve Prolapse
y N	Congenital Heart Defect	y N	Pacemaker
y N	Diabetes	y N	Psychiatric Problems
y N	Difficulty Breathing	y N	Radiation Treatment
y N	Emphysema	y N	Rheumatic / Scarlet Fever
y N	Epilepsy	y N	Seizures
y N	Fainting Spells	y N	Shingles
y N	Frequent Headaches	y N	Sickle Cell Disease / Traits
y N	Glaucoma	y N	Sinus Problems
y N	Hay Fever	y N	Stroke
y N	Heart Attack	y N	Thyroid Problems
y N	Heart Murmur	y N	Tuberculosis (TB)
y N	Heart Surgery	y N	Ulcers
y N	Hemophilia	y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

y N	Aspirin	y N	Erythromycin	y N	Metals
y N	Codeine	y N	Jewelry	y N	Penicillin
y N	Dental Anesthetics	y N	Latex	y N	Tetracycline

Please list any other drugs/materials that you are allergic to: _____

_____

5 Dental History

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

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

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

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

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____

Signature Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA..

OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____