TODAY'S DATE ______________________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________

WHAT IS THE PURPOSE OF YOUR VISIT? ______________________

General Information

Patient Name ______________________ (FIRST / MIDDLE / LAST) Birthdate ____________

Guardian's name if patient is a minor ______________________ (FIRST / MIDDLE / LAST) SS # ____________

Address ______________________ (NUMBER / STREET / CITY / STATE / ZIP)

Home phone ____________ (AREA CODE) Cell phone ____________ (AREA CODE) Email ____________

Occupation ____________ (PARENT/GUARDIAN'S IF PATIENT IS A MINOR) Employer ____________ Work phone ____________ (AREA CODE / EXT)

Business Address ______________________ (NUMBER / STREET / CITY) Preferred Method of Contact ____________

Name of Spouse ______________________ (OR NAME OF OTHER PARENT/GUARDIAN'S) (FIRST / MIDDLE / LAST) SS # ____________

Spouse's Occupation ____________ (OR NAME OF OTHER PARENT/GUARDIAN'S) Spouse's Employer ____________ (OR NAME OF OTHER PARENT/GUARDIAN'S)

Spouse's Business Address ______________________ (OR NAME OF OTHER PARENT/GUARDIAN'S) (NUMBER / STREET / CITY) Spouse's Work phone ____________ (AREA CODE / EXT)

Emergency Information

In case of emergency, list a local friend or relative who does not live with you:

Name ______________________ (FIRST / MIDDLE / LAST) Relationship ____________

Address ______________________ (NUMBER / STREET / CITY) Phone ____________ (AREA CODE)

Please provide another local friend or relative who does not live with you:

Name ______________________ (FIRST / MIDDLE / LAST) Relationship ____________

Address ______________________ (NUMBER / STREET / CITY) Phone ____________ (AREA CODE)

Insurance Information - Please complete if you have any type of Dental Insurance

Insurance subscriber's name ______________________ Subscriber's ID # ____________

Name of insurance co. ____________ Employer ____________ Group # ____________ Birthdate ____________ (SUBSCRIBER'S)

Is there **secondary dental insurance** that also covers this patient?

Insurance subscriber's name ______________________ Subscriber's ID # ____________

Name of insurance co. ____________ Employer ____________ Group # ____________ Birthdate ____________ (SUBSCRIBER'S)

Consent for Services and Policy of the Office

I *grant* permission to Oak Tree Dental Care Doctors and Staff to employ such established treatments and therapy as may be deemed professionally necessary or advisable.

I *authorize* the release of my dental records from Oak Tree Dental Care to other dentists or specialists involved in my dental care. I further authorize the release of my records from any individuals to Oak Tree Dental Care.

I *authorize* insurance payments to be made directly to Oak Tree Dental Care. I understand that I am financially responsible for any unpaid balance. I understand that the patient portion is due at the time of service and is only an estimate based on provided insurance coverage.

I *acknowledge* receipt of the Notice of Privacy Practices.

I *understand* that once an appointment has been made, this time has been reserved especially for me. I am aware that, should I not provide 24-hour notice to change an appointment, I may be charged a fee.

I have read, understood and agree to the above ______________________
Signature of patient, parent or guardian

Patient Name: ____________________

Health Information

Have you ever had any of the following? Please check those that apply:

- ❑Heart Disease or Attack
- ❑Heart Stent or Shunt
- ❑Heart Murmur
- ❑Angina Pectoris
- ❑Artificial Heart or Valve
- ❑Artificial Implants/Joints
- ❑Rheumatic Heart Disease
- ❑Rheumatic (Scarlet) Fever
- ❑Endocarditis
- ❑Stroke
- ❑Eye Disorders
- ❑High Blood Pressure
- ❑Low Blood Pressure
- ❑Cancer/Leukemia
- ❑Radiation/Chemotherapy
- ❑AIDS/HIV Positive
- ❑Hepatitis A,B,C
- ❑Pregnancy
- ❑Asthma
- ❑Diabetes I or II
- ❑Hemophilia
- ❑Hyper/Hypo Thyroidism
- ❑Sickle Cell Anemia
- ❑Blood Transfusion
- ❑Anemia
- ❑Tuberculosis
- ❑Respiratory Problems
- ❑Sinus Trouble/Hay Fever
- ❑Venereal Diseases
- ❑Stomach/Duodenal Ulcers
- ❑Chemical Dependency
- ❑Liver Disease
- ❑Epilepsy
- ❑Psychiatric Care
- ❑Kidney Trouble
- ❑Fainting/Dizziness
- ❑Nervousness
- ❑Bulimia
- ❑Dieting Concerns
- ❑Headaches
- ❑Myalgia
- ❑Bruise Easily
- ❑Arthritis
- ❑Dry Mouth

Medications and Allergies

Do you have any problems with local anesthetics (Novacaine)? .... ❑yes ❑no
Are you/have you ever taken Bisphoshonates (Reclast, Fosomax, Actonel, Boniva, Aredia, Zometa)? .... ❑yes ❑no
Have you ever been hospitalized or had a serious injury? .... ❑yes ❑no

If yes, please explain: ____________________
Are you allergic to: Penicillin, Amoxicillin, or any other Antibiotic? .... ❑yes ❑no

Please Identify: ____________________
Codeine .... ❑yes ❑no
Aspirin .... ❑yes ❑no
Latex .... ❑yes ❑no

Any other allergies? ____________________
Are you taking contraceptives (Birth Control Pills) or any hormones? .... ❑yes ❑no

If yes, please list: ____________________
Please list ALL medications and vitamin supplements currently being taken along with dosage amount:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Dental Health Information

What is your main dental concern? ____________________

Date of last dental exam ____________________ Last cleaning ____________________
Do you need to be pre-medicated for dental treatment? .... ❑yes ❑no
Do you have any sore spots in your mouth? .... ❑yes ❑no
Are you satisfied with the appearance of your teeth? .... ❑yes ❑no
Have you ever been treated for periodontal disease (gum disease)? .... ❑yes ❑no
Have you ever had TMJ (jaw joint) clicking, popping, dislocation, pain? .... ❑yes ❑no
Do you grind your teeth at night (bruxism)? .... ❑yes ❑no
Are there any other health concerns, treatments, and/or conditions we should know about? .... ❑yes ❑no

If so, please explain: ____________________

Date of your last medical exam ____________________ Physician's Name ____________________

Hospital/Office Name ____________________ Physician's Phone ____________________

Previous Dentist ____________________ Phone Number ____________________
To the best of my knowledge, all of the preceding answers and information provided are true and accurate. If I have any changes to my heath/dental history, I will notify my provider immediately.

____________________ ____________________
Signature of patient, parent, or guardian Date