Oak Lane Family Dental Patient Information

Please answer all questions! All information is strictly confidential.

Patient's Name_____ SS#_____

Birth date_____ Work Phone #_____

Home Phone #_____ Cell Phone #_____

Mailing Address_____

Physical Address_____

Email_____

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

MEDICAL HISTORY

Name of Family Physician_____

- Are you currently under a PHYSICIAN'S CARE? □**YES** □**NO**
  If yes, for what?_____
- Are you taking ***ANY*** medications (including vitamins and herbal products)?□**YES** □**NO**
  If yes, what?_____
  _____
- Are you allergic to **ANYTHING**? □**YES** □**NO** If yes, what?_____
  _____
- Have you had any problems as a result of taking **ANY** MEDICATIONS?□**YES** □**NO**
  If yes, please list and describe symptoms_____
- (Women) Is there a chance that you are pregnant?□**YES** □**NO**
  If yes, due date?_____ OB-GYN name and phone#_____
- Has a physician **EVER** told you that you have the following? **Please check YES or NO**.

□**YES** □**NO** Heart Problem

*If "YES", please give type and date*_____

□**YES**	□**NO**	Mitral Valve Prolapse	□**YES**	□**NO**	Stroke or Heart Attack
□**YES**	□**NO**	Rheumatic Fever	□ **YES**	□**NO**	Hepatitis or Jaundice
□**YES**	□**NO**	Any Blood Disease	□**YES**	□**NO**	High Blood Pressure
□**YES**	□**NO**	Tuberculosis (TB)	□**YES**	□**NO**	Low Blood Pressure
□**YES**	□**NO**	AIDS, HIV, ARC	□**YES**	□**NO**	Respiratory (lung) Disease
□**YES**	□**NO**	Hemophilia (bleeding)	□**YES**	□**NO**	Sexually Transmitted Disease
□**YES**	□**NO**	Stomach Disorder	□**YES**	□**NO**	Epilepsy or Seizures
□**YES**	□**NO**	Cancer or Leukemia	□**YES**	□**NO**	Implants
□**YES**	□**NO**	Drug or Alcohol Dependency	□**YES**	□**NO**	Transplants
			□**YES**	□**NO**	Artificial Joints, Screws
□**YES**	□**NO**	Diabetes (Sugar)	□**YES**	□**NO**	Artificial Heart Valves

If you answered YES to any of these, please explain_____

_____

- Have you **EVER** taken the medications Aredia, Fosamax, Zometa, Didrocal, Didronel, Boniva, Actonel, Skelid, or any other bisphosphonate or derivative? □**YES** □**NO**
  If yes, when?_____
- Do you have or have you ever had **ANY** other medical conditions not covered above?
  □**YES** □**NO** If yes, what?_____

If you are under the care of a cardiologist, provide name and phone #_____

SOCIAL HISTORY

- Do you use tobacco products? □YES □NO Smoke? Dip? Chew? (Circle all that apply)
- Do you wish to stop using tobacco products? NEVER! Maybe Soon NOW!
- Have you consumed ANY amount of drugs or alcohol in the past 48 hours? □**YES** □**NO**

DENTAL HISTORY

- Do your gums bleed easily when you brush or floss? **YES** □**NO**
- Are your teeth sensitive to cold or sweets? **YES** □**NO**
- Does food collect between your teeth? **YES** □**NO**
- Is your mouth dry? **YES** □**NO**
- Do you have a sore throat? **YES** □**NO** If YES, is it constant? **YES** □**NO**
- Do you have soreness in your facial muscles or clicking, popping, and discomfort in the jaw area? **YES** □**NO**
- Do you grind or clench your teeth? **YES** □**NO**
- Are you satisfied with your smile? **YES** □**NO** If NO, what would you like to change? _____

INSURANCE INFORMATION

□ I AM NOT COVERED BY DENTAL INSURANCE
□ I AM COVERED BY DENTAL INSURANCE
You must present your card and a photo ID at the time of service

Primary Insurance Company_____ Group Number_____
*Policyholder Name*_____ *Policyholder SSN*:_____
*Policyholder Birthday*_____

Secondary Insurance Company_____ Group Number_____
*Policyholder Name*_____ *Policyholder SSN*:_____
*Policyholder Birthday*_____

By signing this form, I certify that I have answered all of the questions to the best of my knowledge. I understand that failure to accurately answer ANY of the questions could result in a life-threatening complication of my dental treatment.

If representing a minor, I certify that I am the parent, guardian, or personal representative and that there are no court orders in effect that prohibit me from signing this consent. I request and authorize the dentist and dental team members to perform necessary dental services for the child above. This includes, but is NOT limited to radiographs (x-rays) and the administration of anesthetics that are deemed necessary by the dentist. **I understand that I am responsible for ALL costs associated with treatment of this patient.**

I acknowledge that payment is due at the time that services are rendered. I acknowledge that insurance is filed only as a courtesy and that I am responsible for ALL of the treatment costs. I understand that the filing of an insurance claim does NOT relieve me from my responsibility for the payment of ALL charges.

Patient, Guardian, or Representative Signature_____

Date_____ Printed Name_____