

Welcome to Oakwell Dental

3301 Oakwell Court, Suite 102 :: San Antonio, TX 78218 :: Tel: 210 832-9993

Today's Date

Welcome! So that we may provide you with the best possible care, please complete all parts of this medical/dental history form. All information is completely confidential.

PATIENT REGISTRATION

How would you like to be addressed? _____ SSN: _____ Birth Date: _____ Age: _____
Last Name: _____ First: _____ Middle: _____
Address: _____

Gender ? Male ? Female Marital Status ? Single ? Married ? Divorced ? Widowed ? Separated
Driver License Number: _____ Home Phone: _____ Work Phone: _____
Other Phone, Pager or E-Mail: _____
Where/when are the best times to reach you? _____ Whom may we thank for referring you? _____
Other family members seen by us _____ What pharmacy do you usually use? _____
If child, parent's name: _____ Parent's address, if different: _____

EMPLOYMENT AND SUPPLEMENTAL CONTACT INFORMATION

Employer: _____ Address: _____
Length of Employment: _____ yrs _____ mo Occupation: _____
Spouse's Name: _____ Spouse's Employer _____ Work Phone: _____
Spouse's Social Security #: _____ Spouse's Birth Date _____ Driver License #: _____
Emergency Contact: _____ Emergency Contact Phone: _____
Neighbor or Relative not living with you: _____ Relationship: _____
Work Phone: _____ Home Phone: _____

INSURANCE AND PHYSICIAN INFORMATION

PRIMARY Insurance: Medical Coverage? ? Yes ? No: Dental Coverage? ? Yes ? No: Orthodontic Coverage? ? Yes ? No
Insurance Co. Name: _____ Phone # () _____- _____ Group #, Plan, Local, or Policy # _____
Insurance Co. Address: _____ City _____ State _____
Insured's Name: _____ Insured's Soc Sec No: _____ Ins Birth Date _____ Relation _____
Insured's Employer: _____ Employer's Address: _____
SECONDARY Insurance: Medical Coverage? ? Yes ? No: Dental Coverage? ? Yes ? No: Orthodontic Coverage? ? Yes ? No
Insurance Co. Name: _____ Phone # () _____- _____ Group #, Plan, Local, or Policy # _____
Insurance Co. Address: _____ City _____ State _____
Insured's Name: _____ Insured's Soc Sec No: _____ Ins Birth Date _____ Relation _____
Insured's Employer: _____ Employer's Address: _____
Person Responsible for Account if other than yourself: _____ Relationship: _____
Home Phone: _____ Social Security # _____

AUTHORIZATIONS

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

PAYMENT IS DUE AT TIME OF SERVICE

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

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: Have you experienced problems associated with any previous dental work?
- ? Yes ? No: Do you require antibiotics before dental treatment?
- ? Yes ? No: Have you experienced problems associated with any previous dental work? Do you now, or have you ever experienced, pain or discomfort in your jaw joint (TMJ / TMD)?
- ? Yes ? No: Do you floss daily? ? Yes ? No: Brush daily
- ? Good ? Fair ? Poor: Your current dental health is...
- ? Hard ? Medium ? Soft: Type of bristles on your toothbrush...
- How long do you use a toothbrush before replacing it? _____
- ? Yes ? No: Do you use anything more than a toothbrush / floss ?
If yes, what? _____
- ? Yes ? No: Would you like fresher breath? ? Yes ? No: 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 heat, 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 teeth ground, or 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?
If yes, please explain: _____
- ? Yes ? No: Do you use a bite plate or mouth guard?
- ? Yes ? No: Have either of your parents experienced dental problems?
- ? 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: Do you have difficulty chewing 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 own teeth all of your life?
- ? Yes ? No: Do you bite your lips or teeth regularly?
- ? Yes ? No: Are you nervous about having any type of dental treatment?
- ? Yes ? No: Do you hold foreign objects in your mouth (pens, nails, etc)?
- ? Yes ? No: Do you "mouth breathe" 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 mornings?
- ? 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 and least about any dentist you have seen? _____

? 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.

Oakwell Dental - Patient History - Page 3

MEDICAL HISTORY

? Yes ? No: Do you have a personal physician?

Physician's 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 other 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 20 pounds 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

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Thinners	Y N Ibuprofen	Y N Steroids / Cortisone	Y N Have you ever taken Phen-Fen? Also known as Redux or Pondimin?
Y N Antibiotics	Y N Blood Pressure Meds	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. _____

? Yes ? No: If you answered YES to Phen-Fen in the section above, have you had a medical exam of your heart tissue lately?

Do you have, ore have you ever experienced, any of the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches (frequent)	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: _____

