PATIENT INFORMATION

First Name: ____ MI: ________

Last: ____________________________________ Nick Name: ________________________

Home Phone: __________________________________ Work Phone: __________________________________ Cell Phone: __________________________________

DOB: __________________________❑ Male ❑ Female SS#: ____________________________

Address: ____

City: ____________________________________ State: _________ Zip: ______________

Employer: ____

State ID/Driver's License #: _____________________________________

E-mail Address: ____

Name of Physician: ____

Physician Phone: ____

In case of Emergency Contact: ____

Relationship: ________________________ Phone: _____________________________

How did you hear about our office? ____

Patient Dental History

What concerns you most?

____

Are you having discomfort at this time? ❑ YES ❑ No What is the discomfort?

____

How long since you have been to a dentist? __________ Did you have X-Rays? ______ What else was done? ____________________

Are your teeth sensitive to: **Heat** ❑ YES ❑ No **Cold** ❑ YES ❑ No

Sweets ❑ YES ❑ No Sour ❑ YES ❑ No Pressure ❑ YES ❑ No

Have you ever had your teeth straightened? __________ If so, when? ______________ Did you have traditional braces? _________

How often do you brush your teeth? ________________________ How often do you use dental floss? _________________________

Do you have bleeding gums? ___________ Have you ever had gum treatment? ___________

When? __________________________

Do you grind or clench your teeth? ____________ Do you hear popping or clicking noises when you chew? _____________________

Do you have any pain around either of your ears? ________________ Any swelling or lumps in your mouth? ____________________

Do you have any fear of dental treatment?

____

How do you feel about the appearance of your teeth? ____________________

____

Patient Health History

Are you currently under a Physicians care? _________

Physician's Name ____

Physician's Address ____
Physician's Phone ___________________________

Do you or have you experienced any of the following? (Please circle **Y/N**)

Y N Abnormal Bleeding **Y N** Anemia **Y N** Arthritis/Rheumatism **Y N** Artificial Bones/Joints **Y N** Artificial Heart Valves **Y N** Asthma **Y N** Bleeding abnormally **Y N** Cancer

Y N Chemical Dependency **Y N** Chemotherapy **Y N** Congenital Heart Defect

Y N Cortisone Treatment **Y N** Diabetes **Y N** Emphysema **Y N** Epilepsy **Y N** Fever Blisters

Y N Glaucoma **Y N** Headaches **Y N** Heart Attack **Y N** Heart Murmur **Y N** Heart Surgery

Y N Hemophilia **Y N** Hepatitis **Y N** Herpes **Y N** High Blood Pressure **Y N** HIV+/ AIDS

Y N Kidney Problems **Y N** Liver Disease **Y N** Lupus **Y N** Pacemaker **Y N** Psychiatric Care

Y N Radiation Treatment **Y N** Seizures **Y N** Tuberculosis (TB)

Y N Tumor or growth on head or neck **Y N** Venereal Disease

For Women: Are you taking birth control pills? ___________ Are you pregnant? __________

Week #: ___________ Are you nursing? _____________

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc) ❑ YES ❑ No

ALLERGIES

Are you allergic to any of the following? (Please check Y/N)

Aspirin ❑ YES ❑ No   Barbiturates ❑ YES ❑ No

Codeine ❑ YES ❑ No   Erythromycin ❑ YES ❑ No

Iodine ❑ YES ❑ No   Latex ❑ YES ❑ No

Local Anesthetic ❑ YES ❑ No   Penicillin ❑ YES ❑ No

Sedatives ❑ YES ❑ No   Sulfa Drugs ❑ YES ❑ No

Tetracycline ❑ YES ❑ No   Other: ________________________

MEDICATIONS

Please list any and all medications you are currently taking:

____

____

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and

it is my responsibility to inform Oral Implantology Associates of any changes in my medical status. I authorize dental staff to perform the necessary dental services

I may need, including x-rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my dental needs.

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.