Please remember you are financially responsible for your account, regardless of your insurance coverage.

OCEANVIEW DENTAL PATIENT INFORMATION

This information is important for your health care and will be kept confidential

Date ______________ Purpose of visit ____

Are you experiencing any pain? Y / N   If yes, duration and location _______________________________________

Who may we thank for referring you to our office? ____

PATIENT FIRST NAME ____________________________________ **LAST NAME** _____________________________

Marital status ________ ☐ Male ☐ Female Birthdate ______________ SS# _________________________

Home address ____City ____________________ State _____Zip ______

Home phone ___________________ Cell phone ___________________Email ____

Employer ____Employer Phone _________________Ext ________

SPOUSE NAME ___________________________________**LAST NAME** ________________________________

Home Address ____City __________________ State _____ Zip ______

Birthdate ____________ SS# __________________ Cell phone ___________________Email______________________________

Employer _______________________________________ Bus.Phone __________________Ext _______

EMERGENCY CONTACT _________________________________Phone __________________Relationship___________________

****Do you have Dental Benefits? YES NO If yes, please complete a dental insurance questionnaire.**

MEDICAL HISTORY

Name of Primary Care Doctor _________________________________City __________________ Phone ______________

Date of last medical exam ____________________ Do you have a current medical condition? **YES NO**

If yes, please describe ____

A. Have you ever had or do you have any of the following? Please circle Yes or No:

YES	**NO**	Hepatitis, Liver Disease, Jaundice	**YES**	**NO**	Excessive Bleeding requiring treatment
YES	**NO**	Rheumatic Fever	**YES**	**NO**	Venereal Disease, Social Disease
YES	**NO**	Diabetes? Controlled how?___________________	**YES**	**NO**	Lung Trouble (TB, Asthma, Emphysema)
YES	**NO**	High Blood Pressure? Controlled how?__________	**YES**	**NO**	Arthritis, sore joints
YES	**NO**	Heart trouble: _____________________________	**YES**	**NO**	Fainting spells, Epilepsy, Convulsions
YES	**NO**	Heart Murmur, Mitro Valve Prolapse	**YES**	**NO**	Headaches, Migraines
YES	**NO**	Shortness of breath	**YES**	**NO**	Nervous Breakdown
YES	**NO**	Swelling of ankles or feet	**YES**	**NO**	Indium or Cobalt treatments
YES	**NO**	Blood trouble, Anemia, Leukemia	**YES**	**NO**	Tumors or Cancer Kind? ______________ __
YES	**NO**	Serious Accident ____________________________	**YES**	**NO**	Major Operation Kind?__________________
YES	**NO**	Human Immunodeficiency Virus (HIV)	**YES**	**NO**	Herpes Virus
YES	**NO**	Stroke When?______________________________	**YES**	**NO**	Human Papillomavirus (HPV)
YES	**NO**	Acquired Immune Deficiency Syndrome (AIDS)	**YES**	**NO**	Osteoporosis

MEDICAL HISTORY CONTINUED

B. Are you now:

YES NO Pregnant? Due Date?_______________________
YES NO On a prescribed diet
YES NO Using Hormones (incl. birth control)
YES NO Taking vitamins/Supplements

C. Are you now taking medications for any of the following? If so, please list type

YES NO Pain ____________________________________
YES NO Nerves (tranquilizers) ______________________
YES NO Sleeping__________________________________
YES NO Blood (thinners,liver,iron pills)_______________
YES NO Heart_____________________________________
YES NO Has your M.D. advised taking a prophylactic antibiotic prior to dental treatment?
YES NO Thyroid_______________________________
YES NO Arthritis or Rheumatism_________________
YES NO Allergies_______________________________
YES NO Stomach trouble (ulcer, other)____________
YES NO Headaches_____________________________
YES NO Other Medication (please specify)
____

D. Have you ever been sick from, allergic to, or told not to take any of the following? If so, please list:

YES NO Antibiotics_______________________________
YES NO Codeine
YES NO Aspirin
YES NO Latex or Rubber
YES NO Novocaine (or other dental anesthetics)
YES NO Other_________________________________

Do you have any disease, condition, or problem, which is not listed above, we should be advised of? **YES NO**
If so, please explain____

DENTAL HISTORY

Name of previous dentist______________________________________ Date of last visit______________________________________
Last treatment rendered_______________________________________Date of last full mouth set of x-rays_____________________

YES NO Are you dissatisfied with your teeth and their appearance?
* If yes, what concerns you the most?____________________________What would you change? ________________
YES NO Do you have any missing teeth? If yes, why haven't you had them replaced?________________________________
YES NO Are there any growths, unhealed injuries, inflames areas, or swelling in or around your mouth?
YES NO Do you have difficulty swallowing?
YES NO Do your gums bleed when you brush your teeth?
YES NO Have you ever been told you have gum disease (periodontitis, pyorrhea)
YES NO Have you been treated for gum (periodontal) problems?
YES NO Do you have an unpleasant odor, or taste in your mouth or experience bad breath?
YES NO Does food get caught between your teeth? If yes, where?____
YES NO Is any part of our mouth sensitive to temperature, pressure or sweets? If yes, where?__________________________
YES NO Have you ever had orthodontic treatment (braces)?
YES NO Does dental treatment make you apprehensive? _____slightly _____moderately _____extremely
YES NO Have you ever experienced the calming effects of Nitrous Oxide for dental treatment?
YES NO Have you ever experienced any unfavorable reaction to dentistry?
YES NO Do you snore or suspect you snore?
YES NO Do you have a clicking in your jaw joint or have you ever experienced an inability to open your mouth or jaw widely?
YES NO Do you ever awaken with an awareness of your teeth or jaw?
YES NO Do you clench or grind your teeth during the day or night?
YES NO Do you have pain or soreness around your eyes, ears, or other parts of your face, neck or shoulders?

MEDICAL HISTORY UPDATE____

DATE	UPDATE	INITIALS

NOTES:____

____

____

____

____

____

____

____

DENTAL HISTORY CONTINUED____

YES **NO** Has your mouth ever locked open?
YES **NO** Do you have extensive dental crown and bridges?
YES **NO** Do you wear a removal partial or denture? If so, how old is the appliance?__________________________________
YES **NO** Do you feel you have required a lot of dental work in the past?
* If yes, has it been to: _______replace previous dentistry ______repair due to new decay
YES **NO** Do you feel you will lose more teeth and eventually have to wear full dentures?
YES **NO** Do you know that preventative dental care can help eliminate the need for dentures?

Please inquire about any questions which are not understood

All facilities and personnel of this office are expressly here to serve you and your dental health needs; therefore, we ask you to advise us of any change in your medical history, insurance information or mailing address and phone number.

CONSENT OF TREATMENT

I do authorize and give consent to the doctor and his staff to administer treatment, including, but not limited to, local anesthesia and other such treatment which may be necessary for the above-named patient. I also understand that the use of these agents and some procedures embodies a certain risk. I further state that the above medical and dental history was completed fully and accurately to the best of my knowledge. **No treatment will be performed without your prior knowledge and consent. You are required to give us 48 business hours notice to avoid a broken appointment, sterilization and setup fee.**

____

Signature of Patient or Responsible Party **Date**

PATIENT RESPONSIBILITY FOR FEES AND AUTHORIZATION FOR ASSIGNMENT OF INSURANCE BENEFITS

I understand that payment for Dental Services provided in this office for myself or my dependent is my responsibility. Regardless of insurance benefits, unless prior special signed arrangements are made, accounts are to be paid on the date which services are rendered. I hereby authorize that the payment from any insurance company due for services rendered may be paid directly to this office. In the event of default in payment, patient or party responsible for fees agrees to pay any and all costs of suit, collection and attorney’s fees where applicable.

____

Signature of Patient or Responsible Party **Date**