OAKHILL DENTISTRY

PATIENT INFORMATION

Date_____________

Patient Name ____
Last Name

____
First Name Middle Initial

Preferred Name ____

Address ____

City ____

State ________________________ Zip ______________

Home Phone ____

Cell Phone ____

Email ____

Sex ☐ M ☐ F Birthdate_______________________ Age________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _________ years

Social Security #__________________________

Patient Employer / School ______________________________

Occupation ____

Spouse's Name ____

Spouse's Employer ____

Whom may we thank for referring you? ________________________

DENTAL INSURANCE

Who is responsible for this account? ___________________________

Relationship to Patient ______________________________________

Insurance Co. ____

Group # ____

Is patient covered by additional insurance?

Subscriber's Name ______________________________________

Birthdate______________________ SS#______________________

Relationship to Patient ______________________________________

Insurance Co. ____

Group # ____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with

______________________________________ and assign directly to
Name of Insurance Company(ies)

Dr.______________________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent or Guardian

______________________ ______________________________
Date Relationship to Patient

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in your household.)

Name ______________________________________ Relationship ______________________________________

Home (______) ______________________________ Work (______) ______________________________

DENTAL HISTORY

Reason for today's visit___________________

____

Former Dentist ______________________

City/State__________________________

Date of last dental visit ______________

Date of last dental X-rays ______________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath ☐ Yes ☐ No

Bleeding gums ☐ Yes ☐ No

Blisters on lips or mouth ☐ Yes ☐ No

Burning sensation on tongue ☐ Yes ☐ No

Chew on one side of mouth ☐ Yes ☐ No

Cigarette, pipe or cigar smoking ☐ Yes ☐ No

Clicking or popping jaw ☐ Yes ☐ No

Dry mouth ☐ Yes ☐ No

Fingernail biting ☐ Yes ☐ No

Fluoride in any form ☐ Yes ☐ No

Food collection between the teeth ☐ Yes ☐ No

Foreign objects ☐ Yes ☐ No

Grinding teeth ☐ Yes ☐ No

Gums swollen or tender ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No

Lip or cheek biting ☐ Yes ☐ No

Loose teeth or broken fillings ☐ Yes ☐ No

Mouth Habits - *Thumb sucking, pacifier, sleeping with bottle, etc.* ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No

Mouth pain, brushing ☐ Yes ☐ No

Orthodontic treatment ☐ Yes ☐ No

Pain around ear ☐ Yes ☐ No

Periodontal treatment ☐ Yes ☐ No

Sensitivity to cold ☐ Yes ☐ No

Sensitivity to heat ☐ Yes ☐ No

Sensitivity to sweets ☐ Yes ☐ No

Sensitivity to when biting ☐ Yes ☐ No

Sores or growths in your mouth ☐ Yes ☐ No

How often do you floss? __________________

How often do you brush? __________________

CONFIDENTIAL HEALTH HISTORY

Patient Name: ______________________ Date of Birth: _______________

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain ____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain ____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain ____
4. Yes No Are you being treated by a physician now? If YES, explain ____________________
   Date of last medical exam? Reason for exam ____________________
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain ____
   Date of last dental exam ____________________ Name of last treating dentist ____________________
6. Yes No Are you in pain now?
   If YES, explain ____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis
Heart defects	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novocaine or Xylocaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal

Others: ____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin

Please list: ____

VI. WOMEN ONLY (Leave blank if you do not understand the question)

Yes No Are you or could you be pregnant?
If YES, what month? ___________________

Yes No Are you nursing?

Yes No Are you taking birth control pills?

VII. ALL PATIENTS

Yes No Do you have or have you had any diseases or medical problems NOT listed on this form?
If YES, explain ____

____

Yes No Have you ever been pre-medicated for dental treatment? If YES, why ______________________

Yes No Have you ever taken Fen-phen? If YES, when ______________________

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

____

____

____

Pharmacy Name ____

Phone ( ) ____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient Print Name: ______________________________ Date: ______________

Signature of Patient, Parent or Guardian: ______________________________

Physician's Name: ______________________________ Phone : ______________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____

Signature of Patient, Parent or Guardian Date Signature of Dentist Date

Acknowledgment of Receipt of Notice of Privacy Practices

*** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT ***

I,____, have received a copy of the Alan E. Barton, D.D.S. and Scott D. Jereb, D.D.S. Notice of Privacy Practices.

____

Please print name

______________________________________ __________________

Signature of Patient, Parent or Guardian Date

If this Acknowledgment is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name____________________________________

Relationship to the Patient ____

____

FOR PROGRAM USE ONLY

We attempted to obtain written acknowledgment of receipt of your Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please specify) _______________________________________