23RD STREET DENTAL

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2825 NW 23RD ST. | OKLAHOMA CITY, OK 73107

Patient Health History & Information

Name _____ Preferred name _____ Date _____
First Middle Init. Last

Address _____ City_____ State_____ Zip Code_____

Home Phone _____ Work Phone _____ ext. _____

Cell Phone _____ Birth date _____ Social Security _____

Email Address _____ Circle: Child Single Married Divorced Widowed Gender: M / F

Employer Name: _____
City State

Referred by? Coupon Edmond Phone Book SW Bell Phone Book Insurance Co. Location Invisalign

Patient Referral: _____ Other: _____

Emerg. contact _____ Ph. _____

Spouse's Name _____ Birthdate _____ Social Security _____

Spouse's Employer _____ Spouse's Work Phone _____ Spouse's Cell _____

Who is the person responsible for this account? _____ Relationship to patient _____

DENTAL INSURANCE INFO

Insurance Company _____

Name of Insured _____ Birth date_____ Social Security_____

Group Name _____ Group # _____ Phone _____

MEDICAL HISTORY

Physician's Name _____ Phone _____

Have you had any serious illnesses or operations? _____

Have you ever had a blood transfusion? Yes or No If yes, please give approximate dates _____

Have you ever been told you need to pre-medicate prior to dental appointments due to a medical condition? Yes or no

Women: Are you pregnant? Yes or No Due Date: _____ Are you nursing? Yes or No

Are you taking Birth Control Pills? Yes or No Are you planning on becoming pregnant? Yes or No

Please check if you have or have had any of the following:

__ Alcohol/Drug Abuse ___ Diabetes ___ Latex Allergy ___ Stroke

___ Amoxicillin Allergy ___ Epilepsy ___ Migraine Headaches ___ Sulfa Allergy

___ Anemia
___ Anesthetic Allergy
___ Arthritis
___ Artificial Joints
___ Asthma
___ Back Problems
___ Blood Disease
___ Cancer _____
___ Chemotherapy/Radiation
___ Circulatory Problems
___ Codeine Allergy
___ Depression
___ Erythromycin Allergy
___ Fever Blisters
___ Glaucoma
___ Heart Murmur
___ Heart Valve Replacement
___ Hearing Disorder
___ Hepatitis
(please circle A – B – C)
___ High Blood Pressure
___ HIV Positive/ AIDS
___ Joint/Hip Replacement
___ Kidney/Liver Disease
___ Mitral Valve Prolapse
___ Mouth Sores
___ Pacemaker
___ Penicillin Allergy
___ Prolonged Bleeding
___ Psychiatric Problems
___ Respiratory Disease
___ Rheumatic Fever
___ Scarlet Fever
___ STD_____
___ Shortness of Breath
___ Sleep Apnea
___ Swelling of Feet/Ankles
___ Thyroid Problems
___ Tobacco Habit
___ Tuberculosis
___ Ulcer

Other conditions or allergies:
_____
_____
_____

_____

Please list all prescribed and over the counter medications you are currently taking with the correlating diagnosis:

_____

_____

_____

DENTAL HISTORY

Previous Dentist Name _____

When was your last visit to the dentist? _____ When was your last full mouth x-rays taken? _____

How would you rate your smile? Needs Improvement or Excellent

If you had a magic wand what would you change about your smile?

_____

_____

What, if any, would keep you from having dental treatment completed: Fear / Finances / Pain / Time

Circle all that apply

Have you ever had any serious trouble associated with previous dentistry? _____

Have you ever been diagnosed or treated for periodontal disease? (gum disease, pyorrhea, trench mouth) _____

Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

How often do you brush your teeth? _____ Floss? _____ Toothbrush is: Soft / Medium / Hard / Electric

Please check if you have or have had any of the following:

___ Bleeding/Sore Gums
___ Unpleasant Taste/Bad Breath
___ Clicking or Popping Jaw
___ Food Collection between Teeth
___ Biting Cheeks/Lips
___ Snoring
___ Stained Teeth
___ Missing Teeth
___ Partial Dentures
___ Clenching/Grinding Teeth
___ Loose Teeth or Broken Fillings
___ Sensitivity when Biting
___ Sores or Growths in your Mouth
___ Frequent Blisters on lips/mouth
___ Mouth Piercing
___ Ringing in Ears
___ Achy Pain in Teeth
___ Complete Dentures
___ Sensitivity to Heat
___ Sensitivity to Sweets
___ Sensitivity to Cold
___ Orthodontics
___ Difficulty opening or closing jaw
___ Pain in your jaw joint or your face/ear
___ Chipped or Broken Teeth
___ Throbbing Pain
___ Dental Implants

AUTHORIZATION AND RELEASE

In accordance with the Privacy Rules of HIPAA and with my understanding of the Patient Notice that I have read, I am hereby Giving my full consent to Shepherd mall Family to maintain my medical records, transmit, forward and or release information bout

Me, my health information and/or my Personal Health Information to any applicable person(s) or agencies, provided it is in my Best interest and/or for the advancement or continuance of any health care services which I am being treated. I have read and answered the above questions to the best of my knowledge I understand that I am ultimately financially responsible for all Charges . By signing below I acknowledge my understanding of all terms and conditions.

_____ Date _____

Patient name printed

_____ Date _____

Patient signature

~ We are happy to assist you with your insurance; However your co-pay is due the day services are rendered ~