Oasis Dentistry
FAMILY AND COSMETIC DENTISTRY

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PATIENT HISTORY FORM

PATIENT'S NAME: _____ SEX: ❑ M ❑ F

NAME WISH TO BE CALLED: _____ AGE: _____ DOB: _____

CURRENT DENTAL CONCERN _____

PREVIOUS DENTIST _____ PHONE NO. (_____) _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PATIENT ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE (_____) _____ WORK PHONE (_____) _____ CELL PHONE (_____) _____

EMAIL _____ PREFERRED CONTACT METHOD ❑ HOME ❑ WORK ❑ CELL ❑ EMAIL

SOCIAL SECURITY NO. _____ D.L. # _____

EMPLOYED BY _____ HOW LONG _____

~~BUSINESS ADDRESS:~~ _____
STREET CITY STATE ZIP CODE

OCCUPATION (IF STUDENT, WHERE?) _____

❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

NAME OF SPOUSE _____

SPOUSE'S OCCUPATION _____

PERSON RESPONSIBLE FOR THE ACCOUNT/INSURED PARTY

NAME _____ AGE _____ DOB _____ SEX: ❑ M ❑ F

ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE (_____) _____ WORK PHONE (_____) _____

RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ MOTHER ❑ FATHER ❑ OTHER _____

EMPLOYER _____ SOCIAL SECURITY NO. _____

EMPLOYER ADDRESS: _____ D.L.# _____
STREET CITY STATE ZIP CODE

PRIMARY INSURANCE COMPANY _____

INSURANCE PHONE (_____) _____ POLICY NO. _____ GROUP NO. _____

AUTHORIZATION: I HEREBY CONSENT TO THE TAKING OF X-RAYS, PHOTOGRAPHS, AND OTHER NECESSARY RECORDS BEFORE, DURING AND AFTER TREATMENT AND TO THE USE OF SAME BY THIS PRACTICE FOR SCIENTIFIC PAPER DEMONSTRATIONS. I AUTHORIZE JULIE E. MOORE, D.D.S. TO FURNISH INFORMATION TO THE INSURANCE CARRIER CONCERNING TREATMENT RENDERED. I HEREBY ASSIGN TO JULIE E. MOORE, D.D.S. ALL PAYMENTS FOR DENTAL SERVICES RENDERED. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES WHETHER COVERED BY INSURANCE OR NOT. THIS IS A SWORN ACCOUNT.

PATIENT (OR LEGAL GUARDIAN) SIGNATURE _____ DATE _____

HEALTH QUESTIONNAIRE:

Your general health and dental health are related. We are concerned about both. Please complete as accurately as possible. Thank You

Physician's Name: _____

Last physical exam _____ Phone (_____) _____

Address: _____
Street City State Zip Code

Pharmacy Name _____ Phone (_____) _____

In case of emergency contact _____

Address: _____
Street City State Zip Code

Phone (_____) _____ Relationship to patient _____

DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	YES	NO	When
Very high fever with disease as a child	❑	❑	_____
Rheumatic Fever	❑	❑	_____
Congenital Heart Disease	❑	❑	_____
Heart Valve Damage	❑	❑	_____
Heart Valve Replacement	❑	❑	_____
Mitral Valve Prolapse, Heart Murmur	❑	❑	_____
Chest Pain (Angina)	❑	❑	_____
High ___ Low ___ blood pressure	❑	❑	_____
Seizures	❑	❑	_____
Asthma	❑	❑	_____
Pneumonia	❑	❑	_____
Tuberculosis or Other Lung Disease	❑	❑	_____
Bronchitis	❑	❑	_____
Hay Fever	❑	❑	_____
Sinus Trouble	❑	❑	_____
Thyroid problems	❑	❑	_____
Swelling of ankles	❑	❑	_____
Shortness of breath	❑	❑	_____
Faint easily	❑	❑	_____
Lymphatic Disease	❑	❑	_____
Hip, knee or any joint replacement	❑	❑	_____
Ulcers	❑	❑	_____
Jaundice	❑	❑	_____
Hepatitis	❑	❑	_____
Other Liver disease	❑	❑	_____
Arthritis	❑	❑	_____
Taken antibiotics prior to dental treatment	❑	❑	_____

	YES	NO	When
Stroke	❑	❑	_____
Glaucoma	❑	❑	_____
Nervous Disorder	❑	❑	_____
Kidney Problems	❑	❑	_____
Excessive Urination	❑	❑	_____
Excessive Thirst	❑	❑	_____
Diabetes	❑	❑	_____
High ___ Low ___ blood sugar	❑	❑	_____
Anemia	❑	❑	_____
Hemophilia	❑	❑	_____
Other blood disorder	❑	❑	_____
Abdominal bleeding from cut	❑	❑	_____
AIDS/HIV Positive	❑	❑	_____
Back injury	❑	❑	_____
Back pain	❑	❑	_____
Tumor	❑	❑	_____
Cancer	❑	❑	_____
Syphilis	❑	❑	_____
Gonorrhea	❑	❑	_____
Allergies	❑	❑	_____
Allergic to Penicillin	❑	❑	_____
Allergic to Codeine	❑	❑	_____
Allergic to Local Anesthetic	❑	❑	_____
Allergic to Aspirin	❑	❑	_____
Allergic to Metal (jewelry)	❑	❑	_____
Allergic to Latex	❑	❑	_____

List medications you are allergic to _____

LIST ALL MEDICATIONS, HERBAL SUPPLEMENTS OR DRUGS YOU ARE NOW TAKING:

Name of Drug	How often each day	Purpose or disease treated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you smoke ❑ yes ❑ No if so, how many packs per day? _____

Use alcohol? ❑ Yes ❑ No How much per day? _____ How much per week? _____

DO you now or have you ever used tranquilizers? ❑ Yes ❑ No

Do you take a blood thinner? ❑ Yes ❑ No

Have you ever been treated with cortisone or steroid drugs? ❑ Yes ❑ No

Have you ever been treated in the hospital or had any surgery? ❑ Yes ❑ No Dates _____

Are you now or have you been pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Are you currently taking oral contraceptives? ❑ Yes ❑ No

Are you under the care of a physician now? ❑ Yes ❑ No If yes, for what? _____

Have you had any problems with dental treatments? ❑ Yes ❑ No

I, _____ attest that the above information accurate and complete.

Patient's Signature _____ Reviewed _____ Date _____