OAK DENTISTRY
FAMILY • COSMETIC • IMPLANT

Patient Registration

PATIENT INFORMATION

Patient Name _____/_____
First Last MI Preferred Name

Address _____ City_____ State_____ Zip _____

Cell Phone # (_____)_____ Alternative Phone # (_____)_____ (Home/Work/Other)

Email _____ Preferred Communication: ☐ Cell ☐ Email ☐ Other _____

I would like to receive text message appointment reminders: ☐ Yes ☐ No

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birthdate _____/_____/_____ Age: _____ Soc. Sec. # _____-_____-_____ Race/Ethnicity: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student status: ☐ Full Time ☐ Part Time

Employer: _____ Occupation: _____

Emergency Contact:_____ Phone #:(_____)_____ Relationship:_____

How did you hear about us and what inspired you to make an appointment? Please mark all that apply:

☐ Drive By/Sign, ☐ Website, ☐ Insurance, ☐ Coupon, ☐ Direct Mailer/Postcard, ☐ Magazine: _____

☐ Google/Internet search, ☐ Facebook, ☐ Google Plus, ☐ Yelp, ☐ Twitter, ☐ Other: _____

☐ Friend/Family/Staff Member Referral (**Who can we thank?** _____)

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN YOURSELF)

Relationship to Patient: ☐ Parent/Guardian ☐ Spouse ☐ Other: _____

Name: _____/_____
First Last MI Preferred Name

Address_____ City_____ State _____ Zip _____

Cell Phone # (_____)_____ Alternative Phone # (_____)_____ (Home/Work/Other)

Email_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birthdate _____/_____/_____ Age: _____ Soc. Sec. # _____-_____-_____ Driver License #: _____

Employer _____

INSURANCE (PLEASE PRESENT INSURANCE CARDS)

Medical Insurance

Your relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Policy Holder_____ Contact phone number: (_____)_____

Policy Holder SSC# or ID # _____ Policy Holder Birth Date: _____/_____/_____

Insurance Company_____ Insurance Co. Phone (_____)_____

Employer:_____ Group #_____Effective Date: _____/_____/_____

Dental Insurance

Your relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Policy Holder_____ Contact phone number: (_____)_____

Policy Holder SSC# or ID # _____ Policy Holder Birth Date: _____/_____/_____

Insurance Company_____ Insurance Co. Phone (_____)_____

Employer:_____ Group #_____Effective Date: _____/_____/_____

Health History Questionnaire

Patient Name: _____ Today's Date: _____ / _____ / _____

MEDICAL HISTORY

Date of last physical exam? **Primary Care Physician:** **& Phone #:**

MEDICATION: Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐Yes ☐No
If so, please list all, including vitamins, natural or herbal supplements, and inhalers w/ dosage and reason prescribed.

ALLERGIES: Do you have any known allergies or adverse reactions to any medications or environment? ☐Yes ☐No

☐Local anesthetics ☐Latex (rubber) ☐Aspirin ☐Penicillin (Amoxicillin) ☐Sulfa drugs ☐Codeine ☐Metal ☐Certain foods
☐ Other: _____

SURGERIES/SERIOUS ILLNESS: Have you had any serious illnesses, operations or been hospitalized? ☐Yes ☐No
If yes, when and what was the illness or problem?

MEDICAL PROBLEMS: Have you experienced, or been treated for, any of the following?
*****Check the Family boxes if you have a blood relative with the following conditions.**

	Yes	No	Family		Yes	No	Family		Yes	No	Family
AIDS/HIV Positive	☐	☐	☐	Emphysema	☐	☐	☐	Neurological Conditions	☐	☐	☐
Allergies/Immune Disorders	☐	☐	☐	Gastrointestinal Conditions	☐	☐	☐	Osteoporosis	☐	☐	☐
Arthritis	☐	☐	☐	Glaucoma	☐	☐	☐	Psychiatric Disorders	☐	☐	☐
Asthma	☐	☐	☐	Headaches	☐	☐	☐	Genitourinary Disorder	☐	☐	☐
Bisphosphonate therapy	☐	☐	☐	Heart Attack	☐	☐	☐	Respiratory Problems	☐	☐	☐
Blood Transfusion	☐	☐	☐	Heart Diseases	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Blood/Lymph Disorder	☐	☐	☐	Hemophilia	☐	☐	☐	Seizures	☐	☐	☐
Cancer/Chemo/Radiation	☐	☐	☐	Hepatitis or Liver disease	☐	☐	☐	STD (Venereal Disease)	☐	☐	☐
Cardiovascular Diseases	☐	☐	☐	High Blood Pressure	☐	☐	☐	Sickle Cell Disease	☐	☐	☐
Chronic Bronchitis	☐	☐	☐	High Cholesterol	☐	☐	☐	Skin Conditions	☐	☐	☐
COPD	☐	☐	☐	Kidney Disease	☐	☐	☐	Stroke	☐	☐	☐
Diabetes (Type I or II)	☐	☐	☐	Lupus	☐	☐	☐	Thyroid Dysfunction	☐	☐	☐
Ear, Nose, Throat Conditions	☐	☐	☐	Mental Health Disorders	☐	☐	☐	Tuberculosis	☐	☐	☐
Eating Disorders	☐	☐	☐	Muscle, Bone, Joint Disorders	☐	☐	☐	Weight loss/gain	☐	☐	☐

Have you ever had any other illness not listed above? ☐Yes ☐No If yes, please explain:

WOMEN ONLY: Are you?

☐ Pregnant- Due Date:_____ ☐ Trying to get pregnant ☐ Taking birth control pills or hormonal replacement ☐ Nursing

ANTIBIOTIC PROPHYLAXIS Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? **☐Yes ☐ No**

Please mark if you have any of the following:
☐ Artificial (prosthetic) heart valve
☐ Previous infective endocarditis
☐ Damaged valves in transplanted heart

Congenital Heart Disease (CHD):
☐ Unrepaired, cyanotic CHD
☐ Repaired (completely) in last 6 months
☐ Repaired CHD with residual defects

Joint Replacement:
Have you had an orthopedic total joint (hip, knee, elbow, or finger) replacement?
☐ Yes ☐ No If yes, Date:

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐Yes ☐No

SOCIAL HISTORY

Do you drink alcohol?	☐ never	☐ minimal	☐ less than 10 per week	☐ more than 10 per week
Do you use tobacco products?	☐ never	☐ minimal	☐ yes (____packs/day x _____ yrs)	☐ quit _____ yrs ago
Do you use illicit drugs?	☐ never	☐ previous	☐ current	List type _____

DENTAL HISTORY

Date of last dental exam/cleaning? **Last dental X-rays?** **Previous Dentist?**

What is your main concern today?

Do you have any anxiety, fear, or bad experiences associated with the dentist office? ☐ Yes ☐ No If yes, explain:

Do you like the appearance of your smile & teeth? ☐ Yes ☐ No
Do you snore or have you been diagnosed with sleep apnea? ☐ Yes ☐ No

How often do you brush? _____Times/Day

How often do you floss? _____ Times/Week

Are you currently experiencing, have experienced, or been treated for any of the following? Check all that apply

☐ Braces or Invisalign	☐ Drinks non-fluoridated water	☐ Missing teeth	☐ Stained old fillings
☐ Bad odor/unpleasant taste	☐ Food caught between teeth	☐ Non-matching restorations	☐ My Teeth are sensitive to: ☐ Cold ☐ Hot ☐ Sweets ☐ Biting ☐ Other: _____
☐ Broken/chipped tooth	☐ Grind or clench teeth	☐ Partial or Complete Denture	
☐ Clicking/popping of the jaw	☐ Gums bleed while flossing	☐ Periodontal (gum) TX	
☐ Crooked or flared teeth	☐ Jaw joints/muscle pain	☐ Sores/Ulcers in Mouth	☐ Trauma/injury to Jaw
☐ Dry Mouth	☐ Loose teeth/unfitting denture	☐ Stained teeth	☐ Other: _____

What dental procedures or treatments are you most interested in?

☐ Cleaning/regular care	☐ Crown/Bridge/Veneers	☐ Laughing gas w/ TX	☐ Root Canal Therapy
☐ Composite/white fillings	☐ Dental Implants	☐ Periodontal (gum) TX	☐ Tooth Extraction
☐ Cosmetic: Whitening/Bleach	☐ Invisalign (clear braces)	☐ Removable denture/partial	☐ Other: _____

Where would you like your oral health to be in 5, 10, 20 years?

How would you descibe your smile now? Please rate your teeth on a scale of 1-10 (1=worst,10=best).

What would you most like to change about your teeth & oral health to make it a 10 (best)?

Where do you see a difference between where you are now and where you want it to be?

What is most important to you when seeking Dental Care?

☐ Quality of Service ☐ Convenient Office Hours	☐ Technology ☐ Friendliness of Staff	☐ Comfort ☐ Cleanliness of Office	☐ Cost ☐ Other: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the office of any changes in medical status. I will not hold my doctor, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

X Signature of Patient/Legal Guardian: _____ **Date:** _____

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FINANCIAL POLICY

Thank you for choosing Oak Dentistry. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Initial Each Item Below:

_____**Payment Options:**

-Cash, Check, Visa, MasterCard, American Express or Discover Card

- We offer a 5% courtesy accounting adjustment to patients who pay in full for their treatment with cash prior to completion of care for treatment plans of $1000 or more.
- All returned checks will be subject to $25 fee.

-Convenient Monthly Payment Options from More Mastercard

- Low monthly payments with 0% interest for a promotional period of 6 months.
- No annual fees, no application fee, and no pre-payment penalties.
- Approved in minutes at our office (subject to credit approval).

_____**Payment is due at Time of Treatment:** Oak Dentistry requires full payment at the time services are rendered. Most insurance plans do not cover 100% of the cost of your treatment; therefore, you are responsible for paying your deductible and your estimated uninsured portion of charges at the time of your treatment.

_____**Insurance & Estimates:** Oak Dentistry professionals will work with you to better understand and utilize your insurance benefits and as a courtesy we will gladly file the forms necessary to help you receive the benefits of your coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If your insurance company denies coverage or we do not receive payment 30 days from filing your claim, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance company. Although our practice software enables us to estimate your insurance benefits for necessary treatment, we cannot guarantee eligibility or payment from your insurance company. Regardless of estimated insurance coverage, you are responsible for any services not covered by your insurance company.

_____**Appointment Cancellation Policy:** We kindly ask that if you cannot make an appointment to give us a 48-hour notice so that we can make every effort to accommodate other patients in need of treatment. Broken and missed appointments create scheduling problems for our team as well as our other patients; therefore, if a 48-hour notice is not given, a missed appointment/late cancellation charge will be applied to your account in the amount of $50.00 for each hour of time scheduled. We make every effort to be on time and reserve the scheduled time just for you, so in return we ask for your cooperation as we strive to best serve the needs of all of our patients.

If you have any questions please do not hesitate to ask as we are here to help you to get the care you need at Oak Dentistry.

I have read the above financial and cancellation policies and agree to their content.

X _____

Patient, Parent or Guardian Signature

Relationship to Patient

X _____

Patient Name (Please Print)

Date