SOUTHERN OAKS DENTAL

Patient Information

Patient Name: _____Preferred: _____ DOB: _____MALE/FEMALE

Address: _____City_____State_____Zipcode_____

SSN: _____Home #:_____ Cell#:_____

Email: _____Who referred you to our office: _____

SINGLE/MARRIED Employer: _____ Work #_____

Emergency Contact: _____Relationship: _____

Home #_____Cell #_____ Work #_____

Dental Insurance Information

Insured Name: _____DOB: _____ Relationship to Patient: _____

Insurance Company: _____ Phone#: _____

Address: _____Employer: _____

Member ID: _____ Group No._____

Secondary Dental: Insured Name: _____ Relationship to Patient: _____

Insurance Company: _____ Phone#: _____

Address: _____Employer: _____

Member ID: _____ Group No._____

I have verified that the above information is factual and true to the best of my knowledge. I understand that payment, proof of insurance and/or copay is due at the time of service. I authorize Southern Oaks Dental to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____

Patient Signature Date

Why have you come to the dentist today? _____

Are you Currently in pain? Yes No If yes? Location of pain _____

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? Yes No

Your Current Dental Health? Good Fair Poor Do your Gums Bleed? Yes No

Do You like your smile? Yes No If No WHY? _____

How Many times a week do you floss? _____ How Many times a day do you brush? _____

Type of toothbrush? Hard Medium Soft Electric toothbrush

Medical History

Your current physical condition? Good Fair Poor **Do you smoke, use tobacco or vape? Yes No**

Are you taking any prescriptions, over the counter or herbal supplements? Yes No

List of medication_____

_____

Please CIRCLE if allergic to any of the following?

Aspirin **Penicillin** **Clindamycin** **Codeine** **Hay fever**

Ibuprofen **Latex** **Sulfa Drugs** **Jewelry/ Metals** **Dental Anesthetics**

Other Please list any other drugs/Materials that you are allergic to?_____

_____

Have you ever had any of the following diseases or medical problems?

Yes No| Abnormal Bleeding
Yes No| Anemia
Yes No| Artificial Heart Valves
Yes No| Blood Transfusion
Yes No| Cancer
Yes No| Congenital Heart Defect
Yes No| Heart Attack
Yes No| Heart Murmur
Yes No| Heart Surgery
Yes No| Hemophilia
Yes No| High Blood Pressure
Yes No| Low Blood Pressure
Yes No| Mitral Valve Prolapse
Yes No| Pacemaker
Yes No| Ulcers

Yes No| Rheumatic
Yes No| Chemotherapy/Radiation Treatment
Yes No| Asthma
Yes No| Emphysema
Yes No| Herpes/ Fever Blister
Yes No| HIV/AIDS
Yes No| Difficulty Breathing
Yes No| Fainting
Yes No| Shingles
Yes No| Sinus Problems
Yes No| Tuberculosis
Yes No| Venereal Disease
Yes No| Seizures
Yes No| Colitis

Yes No| Glaucoma
Yes No| Arthritis
Yes No| Lupus
Yes No| Thyroid problems
Yes No| Diabetes
Yes No| Kidney Problems
Yes No| Alcohol Drug Abuse
Yes No| Hepatitis
Yes No| Liver Disease
Yes No| Psychiatric Problems
Yes No| Artificial Joints
Yes No| Has your doctor told you that you require antibiotics prior to dental treatment?
Yes No| Hospitalized Why?
_____

For Women Only: Are you taking birth control pills? Yes No Are you Pregnant? Yes No Are you nursing? Yes No

Please List any other condition you may have _____

Do you have a Physician? Yes No Physician Name_____ **Phone #**_____

Last Visit_____ **Are you currently under a Physician care? Yes No Please Explain?** _____

PREFERRED PHARMACY: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand providing incorrect information can be dangerous to my health.

Patient Signature: _____Date: _____

Office use only: I verbally reviewed the medical and dental information with patient named herein.

Initials_____ **Date**_____

Date:_____

Comments_____**intials**_____