Patient Information

Patient Name: _____ DOB: _____MALE/FEMALE
Address: _____City_____State_____Zipcode_____

SSN:_____Home # :_____ Cell#:_____

Email: _____Who referred you to our office:_____

Employer: _____ Work #_____

Emergency Contact Information

Emergency Contact: _____Relationship: _____
Home #_____Cell #_____ Work #_____

Emergency Contact: _____Relationship: _____

Home #_____Cell #_____ Work #_____

Insurance Information

Insured Name: _____DOB:_____ Relationship to Patient: _____

Insurance Company: _____ Phone#: _____

Address: _____

Policy No._____ Group No._____

Dual Coverage? _____

Insured Name: _____ Relationship to Patient: _____

Insurance Company: _____ Phone#: _____

Address: _____

Policy No._____ 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 pervious 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_____

Are you allergic to any of the following?

Yes No| Aspirin **Yes No| Penicillin** **Yes No| Clindamycin** **Yes No| Codeine** **Yes No| Hay fever**

Yes No| Ibuprofen **Yes No| Latex** **Yes No| Sulfa drugs** **Yes No| Jewelry/ Metals** **Yes No| Dental Anesthetics**

Yes No| 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 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| 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| Ulcers
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?**_____

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

Initials_____ **Date**_____

Date:_____
Comments_____**intials**_____

Photo Consent: If any before/after photos are taken of dental work performed, I give Dr. Markle permission to use photos for educational purposes and lecture presentation.

Patient Signature: _____Date: _____

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: _____