OAKWOOD
DENTAL

Welcome to our office!!

Patient Information

Patient Name: _____ Date:
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #:_____ Birth Date: _____

Driver License#:_____E-mail Address:_____

Phone (Home): _____ Mobile:_____ (Work): _____

Address:_____
Street

_____
City State Zip Code

Emergency Contact:_____ Phone #_____

How did you hear about our office? (Check all that apply):

☐ Google ☐ Website ☐ Facebook ☐ Instagram ☐ Drive by ☐ Other: _____

☐ Patient/word of mouth: _____

Guardian Information (For patient under 18 ONLY)

Mother/Guardian _____ **Phone #:**_____

Father/Guardian _____ **Phone #:**_____

Other guardians (if applicable) _____ ___ **Phone #:**_____

***How is this guardian related to the patient? (Stepparent, etc.):** _____

Health Information

Have YOU ever had any of the following? Please check those that apply

☐ Allergy- Codeine
☐ Allergy- Erythro
☐ Allergy- Hay Fever
☐ Allergy- Ibuprofen
☐ Allergy- Iodine
☐ Allergy- Latex
☐ Allergy- Other_____
☐ Allergy Penicillin
☐ Allergy Sulfa
☐ Allergy- Tylenol
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Dental Anxiety
☐ Diabetes
☐ Dizziness/ Fainting
☐ Emphysema
☐ Epilepsy/ Seizures
☐ Excessive Bleeding
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Heart Valve Replacement
☐ Hepatitis Type____
☐ High Blood Pressure
☐ HIV/ AIDS
☐ Kidney Disease- No Advil
☐ Liver Disease
☐ Mental Disorders
☐ MVP
☐ Nervous Disorder
☐ Pacemaker
☐ Pregnancy
Due Date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Shortness of Breath
☐ Sinus Problems
☐ Smoke/ Tobacco Use
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Other:_____

List of medications you are currently taking (with reason listed)

(Feel free to use the back of this page, or bring your own, up-to-date list of medications with you)

_____

_____

_____

_____

_____

_____

_____

_____

☐ My gums bleed
☐ I have had a periodontal/deep cleaning
☐ I clench/grind my teeth
☐ I am interested in teeth whitening
☐ I am interested in braces
☐ My doctor recommended antibiotics prior to dental visits

Date of last Dental visit:_____ Reason for today's visit: _____

Are you interested in braces/ Invisalign treatment? ☐ Yes ☐ No

- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____

Signature of patient (or parent/guardian if patient is under 18 years of age.)

Spouse or Responsible Party Information

The following is for: The person responsible for payment/ Head of Household (the person filling out the form)

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ Birth Date: _____ Email address: _____

Phone (Home): _____ (Mobile): _____ (Work): _____

Address: _____

Street Apartment #

_____

City **State** **Zip Code**

Employment Information

The following is for: ☐ The patient ☐ Head of household/person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Social Security #: _____

Insured's Birth Date: _____ ID# _____ Group #: _____

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Social Security #: _____

Insured's Birth Date: _____ ID# _____ Group #: _____

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____