OXFORD VALLEY DENTAL Excellence

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Patient Number_____ A B B- C

Health History & Registration

PATIENT INFORMATION (if Minor)

PATIENT'S NAME Last _____ First _____ Middle Initial _____ Sex: M F BIRTHDATE:_____AGE: _____

SOC SEC #: _____ If Patient is a Minor, give Parent's or Guardian's Name: _____TODAY'S DATE: _____

Who May We Thank for Referring You to Our Office? _____ Reason for this Visit: _____

PATIENT INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt. #_____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt. #_____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

PREVIOUS ADDRESS (If less than 3 yrs.) Street _____ City_____ State_____ Zip_____ How Long _____

SOC SEC # _____ BIRTHDATE _____DRIVERS LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

EMERGENCY CONTACT INFORMATION

NAME _____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

REFERRAL SOURCE

Whom may we thank for referring you? :

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor

Name: _____

Or did you find us on your own:

☐ Yellow Pages ☐ Yellow Book ☐ Billboard ☐ Mail ☐ Radio

☐ Insurance ☐ Web ☐ Sign ☐ Magazine _____

☐ Newspaper_____ ☐ Other _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name: _____
Insurance Co.: _____ E-MAIL _____
Insurance Co. Address: _____
Insured's Employer: _____
Insured's Soc Sec #: _____Group #: _____Local #:_____

PATIENT EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

Employer Phone Number _____

*DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, DATE:		
Last FULL MOUTH X-RAYS, DATE (16 small films or panoramic):		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental Health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full?)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENT	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth sensitive to hot, cold sweets pressure?(circle)	☐	☐
Are you unhappy with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING, or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth? (orthodontics)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Name of Previous Dentist:		
City: State:		
How do you feel about your teeth?		

MEDICAL UPDATE

DATE	PATIENT SIGNATURE	DOCTOR SIGNATURE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Are you ALLERGIC to any MEDICATIONS? ☐ No ☐ Yes _____		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe, or chewing tobacco? (circle)	☐	☐

PLEASE √ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Fainting	☐	☐	Pacemaker/heart surgery	☐	☐
Anaphylaxis	☐	☐	Food Allergies	☐	☐	Psychiatric care	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Rapid weight gain/loss	☐	☐
Arthritis	☐	☐	Headaches	☐	☐	Radiation treatment	☐	☐
Artificial heart valves	☐	☐	Heart murmur	☐	☐	Respiratory disease	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)			Rheumatic	☐	☐
Asthma	☐	☐	_____	☐	☐	Shingles	☐	☐
Atopic (allergy prone)	☐	☐	Hemophilia	☐	☐	Shortness of breath	☐	☐
Back problems	☐	☐	Herpes	☐	☐	Skin Rash	☐	☐
Blood disease	☐	☐	Hepatitis	☐	☐	Spina bifida	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Stroke	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Surgical implant	☐	☐
Chemotherapy	☐	☐	Kidney disease	☐	☐	Swelling of feet/ankles	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Thyroid disease	☐	☐
Cortisone treatments	☐	☐	Malnutrition	☐	☐	Tobacco habit	☐	☐
Cough	☐	☐	Material allergies	☐	☐	Tonsillitis	☐	☐
Cough up blood	☐	☐	(latex, wool, metal, chemicals)	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Epilepsy	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐

Family Physician:_____ Phone_____ Email _____

Patient Signature: _____ Date: _____ Dentist Signature: _____