BRODIE OAKS
DENTAL CLINIC

Dental Registration & History

Patient Information

Date_____ SS#_____
Patient_____
Address_____
City_____ Zip_____
Sex ☐ M ☐ F Age_____ Birth Date_____
☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced
Occupation_____
Employer_____
Drivers License #_____
Employer Phone (___)_____
Spouse's Name_____
Birth Date_____SS#_____
Occupation_____
Spouse's Employer _____
Spouse's Work (___)_____

How did you hear about us?
☐ Other Patient - Name:_____
☐ Yellow Pages ☐ Website _____
☐ Newspaper ☐ Search Engine _____
☐ Insurance

Have you or a family member ever been seen in this office? ☐ yes ☐ no

Insurance Information

Who is responsible for this account?_____
Relationship to Patient_____
Insurance Co._____
Group #_____
Is patient covered by additional insurance? ☐ yes ☐ no
Subscriber's Name_____
Birth Date_____
Relationship to Patient_____
Insurance Co._____
Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

_____
Responsible Party Signature

_____
Relationship Date

Contact Information

Home (___)_____ Work (___)_____ Ext_____ Cell: _____
email: _____
Best time and place to reach you _____
Would you prefer email confirmation of your appointments? ☐ yes ☐ no

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household)
Name_____ Relationship_____
Home Phone(___)_____Work Phone(___)_____

Dental History

Reason for today's visit_____
Former Dentist_____ City/State_____
Date of last dental visit_____ Date of last dental X-rays_____

Check (X) if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe or cigar smoking
- ☐ Cosmetic problem
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between the teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tenderness
- ☐ Lip or cheek biting
- ☐ Loose or broken teeth/ fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity treatment
- ☐ Sensitivity to heat/cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?
_____
How often do you brush?
_____

BRODIE OAKS
DENTAL CLINIC

Health History

Physician's Name _____ Date of Last Visit _____

Check (**X**) if you've had any of the following:

- ☐ Acid Reflux
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints (Date:_____)
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back Problems
- ☐ Bleeding abnormally with extractions or surgery
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes (Type_____)
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis (Type_____)
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HRT
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker (Date: _____)
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis (Date: _____)
- ☐ Tumor or Growth on Head or Neck
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Weight Loss, Unexplained

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due Date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name_____

Phone (____) _____

Allergies

List any allergies:

- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Azithromycin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Epinephrine
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other_____

_____

Updates (For Office use only)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____Date_____

Are you taking any new medications? ☐ Yes ☐ No If so, what _____

Patient's Signature _____ Date_____

Doctor's Signature _____

.....

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____Date_____

Are you taking any new medications? ☐ Yes ☐ No If so, what _____

Patient's Signature _____ Date_____

Doctor's Signature _____