Desert Oasis Family Dentistry

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PLEASE PRINT

PATIENT INFORMATION

❑ MR. ❑ MRS. ❑ MISS ❑ MS ❑ CHILD

NAME ______________________________ ❑ MALE ❑ FEMALE
FIRST MIDDLE LAST

ADDRESS ______________________________
NUMBER STREET CITY STATE ZIP

DATE OF BIRTH ______________ SOCIAL SECURITY NUMBER ______________

EMPLOYER or SCHOOL ______________________________
NAME ADDRESS PHONE NO.

INSURANCE COMPANY ______________________________

CELL PHONE ______________ WORK PHONE ______________ EMERGENCY PHONE ______________

RESPONSIBLE PARTY INFORMATION

❑ DR. ❑ MR. ❑ MRS. ❑ MISS ❑ MS

NAME ______________________________ ❑ MALE ❑ FEMALE DOB ________
FIRST MIDDLE LAST

ADDRESS ______________________________
NUMBER STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER ______________ HOME PHONE NO. ______________

EMPLOYER ______________________________
NAME ADDRESS PHONE NO.

PATIENT RELATIONSHIP TO RESPONSIBLE PARTY ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER

OTHER INFORMATION

HOW DID YOU HEAR ABOUT US?

❑ INTERNET ❑ DIRECT MAILINGS ❑ NEWSPAPER ❑ ANOTHER PATIENT OF THIS OFFICE

______________________________ OTHER ______________
NAME ADDRESS

IS ANYONE IN YOUR FAMILY A PATIENT HERE? ❑ NO ❑ YES NAME(S) ______________

IN CASE OF EMERGENCY CONTACT:

RELATIVE ______________________________
NAME ADDRESS PHONE RELATIONSHIP

FRIEND ______________________________
NAME ADDRESS PHONE

____
NAME ADDRESS PHONE

DENTURE PATIENTS

FULL UPPER ❑ YES ❑ NO AGE OF DENTURE ______ PARTIAL UPPER ❑ YES ❑ NO AGE OF PARTIAL ______

FULL LOWER ❑ YES ❑ NO AGE OF DENTURE ______ PARTIAL LOWER ❑ YES ❑ NO AGE OF PARTIAL ______

APPROXIMATE DATE OF EXTRACTIONS ______________________ (MONTH / YEAR)

MEDICAL ALERT

HAVE YOU HAD ANY OF THE FOLLOWING? YES OR NO

	Yes	No	Date
Heart Trouble			
High Blood Pressure			
Epilepsy			
Hepatitis Type A Type B Type C			
Diabetes			
Cancer or Radiation			
Excessive Bleeding			
Nervous Disorders			
Liver Trouble			
Anemia			
HERPES			
AIDS			
Do you live with anyone with HIV, Aids, Herpes or Hepatitis?			

	Yes	No	Date
Rheumatic Fever			
Heart Murmur			
Ulcers			
Stroke			
T.B. (Tuberculosis)			
Prosthetic Devices			
Heart Valve Prosthesis			
Heart or Lung Surgery			
Artificial Joint Surgery			
Other Medical Condition not listed			

WOMEN	Yes	No
Are you taking Birth Control Pills?		
Are you pregnant now?		

If yes, Due date ______________________

Are you taking any medications at this time? ❑ Yes ❑ No

Have you ever taken PhenFen? ❑ Yes ❑ No

Please explain the above "yes" answers

____

Are you allergic to any of these drugs:

	Yes	No
Penicillin:		
Barbiturate:		
Aspirin:		
Codeine:		
Other:		
Latex:		

Local Anesthetic such as:

Novocaine		
Lidocaine		

If yes, what happened? ______________

____

Date: ______________

Are you under the care of a physician? ❑ Yes ❑ No

If yes, why? ______________________

How can we help you today? ______________________

____

____

Signed: ______________________

Parent or Guardian if minor: I give permission to treat ______________________

Relationship to Patient ______________________

Signed: ______________________

Smile Survey

Do you like the color of your teeth? YES NO

Do you like the way your teeth look? YES NO

If no, what would you change? CROWDING SPACING Other ______________

Do you experience any popping, aching, or discomfort in your jaws? YES NO

Do you currently have any pain with your teeth? YES NO

DATE	TAG #	CODE	PROCEDURE COMPLETED	DA	DDA/RDH	FEE

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SS Rev. 03/14