POST OAK DENTAL

WELCOME TO OUR PRACTICE

ABOUT YOU—Please Print All Information

Today's Date:_____

Birthdate: _____/_____/_____ ☐ **Male** ☐ **Female**

Age: _____ Social Security #:_____

Name: _____
LAST FIRST M.I. Mr. Mrs. Ms. Dr.

I prefer to be called: _____

Home Address : _____
Street City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Best time / place to reach you?** _____

Email: _____ Who may we thank for referring you? _____

Other family members seen by our practice: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address : _____
Street / P. O. Box City State Zip

Neighbor or Relative NOT living with you

Name: _____ **Relation:** _____ **Cell Phone:** _____ **Work Phone:** _____

Address : _____
Street / P. O. Box City State Zip

Spouse Information / If Applicable

Name: _____ Birthdate: _____/_____/_____ Social Security #: _____
LAST FIRST

INSURANCE INFORMATION

Primary Insurance: **Dental Coverage?** ☐ **Yes** ☐ **No**

Insurance Co. Name: _____ Phone # _____ Group # (Plan, Local or Policy #) _____

Insurance Co. Address : _____
Street / P. O. Box City State Zip

Insured's. Name: _____ **Insured's Social Security #** _____ **Insured's Birthdate**: ____/ ____/ ____ **Relationship:** _____

Insured's Employer: _____ **Employer's Address :** _____
Street / P. O. Box City State Zip

Have you ever had a bad experience at the dentist? _____

_____

Do you like going to the dentist?_____

Hobbies: _____ **Recent travels?** _____

Our Mission Statement:

Our goal is to provide each and every patient with the very best individualized dental care in the most supportive and nurturing manner possible. We are committed to prevention, early detection and minimally-invasive techniques to promote and maintain your complete oral health.

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush Daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? ☐ Yes ☐ No

Do you have mobility in your teeth? ☐ Yes ☐ No

Do you still have your wisdom teeth? ☐ Yes ☐ No

Previous / Present Dentist: _____

Last Visit Date: _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Address: _____

_____

Phone # (____) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No
If yes, please Explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

If yes, what form of tobacco? _____

Female Patients: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week # _____ Nursing? _____

If you have had breast augmentation, have you discussed the need for prophylactic antibiotics prior to dental work to prevent infection or encapsulation? *(This procedure is like having joint replacement surgery)*

Do You Have or Have You Experienced Any of the Following?

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer _____
Y N Chemotherapy
Y N Chicken Pox

Y N Colitis
Y N Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Ever Hospitalized
Y N Fainting Spells
Y N Fever Blisters
Y N Glaucoma

Y N Hay fever
Y N Headaches
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Kidney Problems

Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Valve Prolapse
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures

Y N Shingles
Y N Sickle Cell
Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke
Y N Thyroid Problems
Y N Tonsillitis
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription or over-the-counter medications or supplements? ☐ YES ☐ NO If yes, please list everything you are taking: _____

_____

Are you allergic to any of the following?

Y N Aspirin Y N Codeine Y N Erythromycin Y N Jewelry / Metals Y N Penicillin Y N Sulfa Drugs
Y N Barbiturates Y N Dental Anesthetic Y N Ibuprofen / NSAIDs Y N Latex Y N Sedatives Y N Other

Please list any other substances / foods that cause allergic reactions: _____

_____

What happens to you? _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible and / or balance that my insurance does not cover. I have received a copy of this office's HIPAA policy.

Signature: _____ **Date:** _____