Oak Grove Dental Center

Welcome!

Thank you for choosing Oak Grove Dental Center! Please take a few minutes to fill out both sides of this form as thoroughly as you can. If you have any questions, please ask – we are here to help!

PATIENT INFORMATION

Full Name: _____

Preferred Name: _____

☐ Male ☐ Female

Birth Date: _____ /_____ /_____

SS#_____ - _____ - _____ (required)

Home Address:

_____

_____

City: _____ State: _____

ZIP: _____

Mailing address: (if different from home address)

_____

_____

City:_____ State:_____ZIP:_____

Email: _____

Cell #: _____

Do you use text messaging? ☐ Yes ☐ No

Home #: _____

Work #:_____ Ext. _____

Employer: _____

Occupation: _____

May we contact you at work? ☐Yes ☐ No

Emergency Contact:

Name: _____

Phone: _____

Relationship to Patient: _____

Who may we thank for referring you?

_____

DENTAL INSURANCE

Primary Coverage

Insured/Policy Holder_____

Birth date:_____/_____/_____ SS#: _____-_____-_____

Insured's Employer: _____

Relationship to insured: _____

Name of Insurance. Co.: _____

Insurance Address: _____

_____

Insurance Phone: _____

ID/Group #:_____

Secondary Coverage

Insured/Policy Holder_____

Birth date:_____/_____/_____ SS#: _____-_____-_____

Insured's Employer: _____

Relationship to insured:_____

Name of Insurance Co.: _____

Insurance Address:_____

_____

Insurance Phone: _____

ID/Group #: _____

RESPONSIBLE PARTY (If different from patient)

Name: _____

Date of Birth:_____/_____/_____ SS#_____-_____-_____

Home address:_____

City:_____State:_____Zip:_____

Home #:_____Work #:_____Ext _____

DENTAL HISTORY

What brings you in today?_____

_____

_____

Are you currently in pain? ☐ Yes ☐ No

Your current dental health is:

☐ Good ☐ Fair ☐ Poor

Do you now have, or have you ever, experienced pain/discomfort in your jaw joint (TMJ/TMD)?

☐ Yes ☐ No

Do you get headaches? If so, how frequently?

_____

Do you clench/grind your teeth? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever been treated for Gum Disease/ Periodontal Disease? _____

How many times per day do you brush?_____

How often do you floss? _____

List any other concerns you would like Dr. Speer to know:_____

_____

_____

Previous Dentist: _____

City/State: _____

Last Visit Date: _____

Date of Last Xrays: _____

Please rank your concerns regarding dental treatments 1-3 with 1 being most important:

____ Cost of treatment
____ Fear of pain or discomfort
____ Missing work time

What motivates you to come to the dentist? Please rank 1-4 with 1 being most important:

____ Maintaining good overall health
____ Avoiding discomfort with teeth
____ Maintaining a beautiful smile
____ Maintaining a good ability to chew and function

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone#:_____ Date of Last Visit? _____

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

Are you currently under the care of a physician? ☐ Yes ☐ No

Please Explain: _____

Are you taking any prescriptions/over the counter drugs?
☐ Yes (If so, please list:) ☐ No

_____

_____

Are you taking any herbal or vitamin supplements, if so please list:

_____

Are you currently taking or have you ever been on osteoporosis drugs such as Fosamax? ☐ Yes ☐ No Please list: _____

For Women: Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes (# of weeks _____) ☐ No

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following?

☐ Tobacco Habit
☐ Heart Attack/Stroke
☐ Cancer/Chemotherapy
☐ Heart Murmur
☐ Rheumatic Fever
☐ HIV + / AIDS
☐ Heart Surgery/Pacemaker
☐ Mitral Valve Prolapse
☐ Kidney Problems
☐ Artificial Bones/Joints
☐ Artificial Valves
☐ Herpes/Cold Sores
☐ High/Low Blood Pressure
☐ Blood Transfusion
☐ Glaucoma
☐ Diabetes: Type I or Type II
☐ Asthma/Emphysema/Difficulty Breathing
☐ Epilepsy/Seizure/Fainting spells
☐ Tuberculosis (TB)
☐ Drug/Alcohol Abuse
☐ Sleep Apnea
☐ Anemia/Hemophilia
☐ Congenital Heart defect
☐ Radiation Treatment
☐ Arthritis/Rheumatism
☐ Developmental Disability
☐ Hospitalization for any reason
☐ Hepatitis: Type A B C
☐ Severe/Frequent Headaches
☐ Other:_____

Are you allergic to any of the following:

Y / N Penicillin
Y / N Tylenol
Y / N Erythromycin
Y / N Latex
Y / N Tetracycline
Y / N Epinepherine
Y / N Codeine
Y / N Clindamycin
Y / N Nickel
Y / N Vicodin
Y / N Sulfa
Other: _____

Dr. Comments:

_____

I authorize Dr. Speer and his staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I also authorize Dr. Speer to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agent, medications, and some dental procedures embody a certain risk. I authorize my insurance company to pay Oak Grove Dental Center all the insurance benefits for services rendered. I also authorize the release of all information necessary to secure the payment of benefits.I understand that I am financially responsible for all charges whether or not they are covered by my insurance.*I also acknowledge that my payment is due at the time of treatment, unless prior arrangements have been approved.*

Patient Signature (Parent/Guardian): _____ **Date:** _____