Patient Health Record

WHITE OAK DENTAL, PLLC

WELCOME to our office. Please help us by filling out this form as accurately as you can. Thank you.

Patient's Name__________ Date__________ Home Phone # __________
Home Address__________ Cell Phone # __________
City__________ State______ Zip______ E-Mail __________
Your Employer__________ Occupation__________ Work Phone # __________
Your Employer Address__________
Your Soc. Sec. No__________ Date of Birth__________ Marital Status M S D W
How did you hear about our office? __________
Names of dependent children (where applicable)__________

____

Type of financial responsibility (please check)

☐ Personal responsibility

☐ Co-responsibility with dental insurance program

Insurance Patients Only

Personal Dental Insurance Information

Name of Dental Plan__________

Active or retired__________ Group No__________ Policy No__________

Spouse Dental Insurance Information

(When both you and your spouse have separate insurance plans please fill out both sections and present a copy of each insurance card for coordinated benefits.)

Name of spouse__________ Date of Birth__________

Spouse's employer & address __________

Telephone at work__________ Spouse Soc.Sec.#__________

Name of Dental Plan__________

Policy No.__________ Active/retired__________ Group No.__________

Office Use Only

Eligible Noneligible
Effective date ______
Max______
Life______ Annual______
Deductible______
OK'd by______

Eligible Noneligible
Effective date ______
Max______
Life______ Annual______
Deductible______
OK'd by

Insurance: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for payment of fees. We will prepare necessary forms or reports to help the persons responsible obtain benefits from insurance companies, after receipt of full or partial payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc. which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for the patient.

My signature below indicates that the above information given is accurate to the best of my knowledge, that I have received & acknowledged the Notice of Privacy Practices of this office and that I give permission to use this signature when processing insurance claims & making credit card transactions.

Signature__________ Date__________

MEDICAL HEALTH HISTORY

Are you in good health (Please circle) EXCELLENT GOOD FAIR POOR

Name & location of physician____

Phone ____________________Date of last complete physical _______________

Are you taking any medication now: Yes _____ No_____

Please list :____

____

ATTENTION

Do you currently have or have you ever been treated for:

Please answer carefully.

Y N		Y N		Y N	
___ ___	Abnormal Bleeding	___ ___	Fever Blisters	___ ___	Pneumocystitis
___ ___	Allergies	___ ___	Frequent Headaches	___ ___	Psychiatric Problems
___ ___	Anemia	___ ___	Glaucoma	___ ___	Radiation Therapy
___ ___	Angina Pectoris	___ ___	HIV+ AIDS	___ ___	Rheumatic Fever
___ ___	Arthritis	___ ___	Hay Fever	___ ___	Seizures
___ ___	Artificial Heart Valve	___ ___	Heart Attack	___ ___	Shingles
___ ___	Asthma	___ ___	Heart Surgery	___ ___	Sickle Cell Disease
___ ___	Are you on a Blood Thinner	___ ___	Hemophilla	___ ___	Sinus Problems
___ ___	Blood Transfusion	___ ___	Hepatitis A B C	___ ___	Stroke
___ ___	Cancer-Chemotherapy	___ ___	High Blood Pressure	___ ___	Taken Fen-Phen
___ ___	Colitis	___ ___	Joint Replacement	___ ___	Thyroid Problems
___ ___	Congenital Heart Disease	___ ___	Kidney Problems	___ ___	Tuberculosis
___ ___	Diabetes	___ ___	Liver Disease	___ ___	Ulcers
___ ___	Difficulty Breathing	___ ___	Low Blood Pressure	___ ___	Venereal Disease
___ ___	Drug/Alcohol Abuse	___ ___	Mitral Valve Prolapse	___ ___	Yellow Jaundice
___ ___	Emphysema	___ ___	Major Surgery (any)	___ ___	Other ____________
___ ___	Epilepsy	___ ___	Pace Maker		____________________
___ ___	Fainting Spells				
___ ___	Do you smoke or use tobacco?				

Allergies:

Y N	
___ ___	Aspirin
___ ___	Codeine
___ ___	Dental
___ ___	Anesthetics
___ ___	Erythromycin
___ ___	Jewelry
___ ___	Latex
___ ___	Metals
___ ___	Penicillin
___ ___	Tetracycline
___ ___	Other ________

____

____

____

Date of last flouride treatment

____

Females only:

Y N		Y N	
___ ___	Are you taking birth control?	___ ___	Are you nursing?
___ ___	Are you pregnant? Week # _____		

DENTAL HISTORY

Reason for visit ________________________________

When was your last dental visit? _______________________ How often do you actually brush all your teeth?________________

How often do you floss? ___ Daily ___ Weekly ___ Monthly ___ Never or rarely ___ Don't know how

Do your gums feel tender or swollen?-- Yes___ No___

Do your gums bleed while brushing or flossing?-- Yes___ No___

Do you avoid brushing any part of your mouth because of pain?-- Yes___ No___

Do you feel twinges of pain when your teeth come in contact with hot, cold or sweet foods or liquids? ---------------- Yes___ No___

Do you have frequent indigestion?-- Yes___ No___

What is your blood type?-- A___ B___ AB___ O___ Don't know___

Do you clench or grind your teeth or jaw while sleeping or during the day?-- Yes___ No___

Do you have frequently headaches or pain about your ears, temples, or neck?-- Yes___ No___

Do you have moderate to great stress in your life?-- Yes___ No___

Have you ever worn braces on your teeth?-- Yes___ No___

Have you ever had a Root Canal treatment? --Yes___ No___ Don't know___

If yes, how many?________

Did either parent lose all of their teeth?-- Yes___ No___

Are you interested in improving your ability to chew your food? -- Yes___ No___

Are you interested in improving the appearance of your teeth? -- Yes___ No___

Are you interested in improving the appearance of your smile? -- Yes___ No___