TULSA DENTAL CENTER

General Dentistry for the Entire Family

Patient Information

Patients full name (Please Print) _____ Preferred _____

Circle: Male/ Female Age_____ Date of Birth _____SSN _____

Parent/Guardian name _____ DOB _____

Mailing Address: _____

Apt #_____City _____ State _____ Zip _____

Home # _____ Cell # _____Business # _____

Emergency Contact: _____ Phone # _____

Relationship: _____

Email _____

Has any member in your family been a patient in this office before? YES / NO

If YES, please give name and relationship:

_____

_____

How did you hear about us? Who referred you? (We would like to thank them)

_____

Authorization and Financial Responsibility

Are you covered by a dental plan? Yes __ No __ Are you the policy holder? Yes __ No __

Last Dental Visit _____ Have you received previous care under this plan? Yes __ No __

If No, who is the main policy holder for your dental coverage? _____

What is your relationship to the policy holder? _____

Policy Holder Information

Employer _____ Dental INS Carrier _____

SSN _____ Policy ID # _____

Date of Birth _____ Group # _____

INS Contact # _____

I hereby authorize the doctor or the associates to perform any and all treatment and consent to such methods, drugs and agents as may be indicated in connection with my dental care. I also authorize the Doctor or any agent working in her behalf, to use any radiograph or photograph for scientific publication or presentation. I understand that payment is expected on the day of service. I agree to pay all legal fees, court costs, and interest charges to the doctor pertaining to the collection of my delinquent account. This consent shall remain in effect until cancelled.

Signature of Patient/Guardian _____ Date _____

Dental History

Is this the patient's first dental visit? Yes___ No ___ Previous Dentist _____

Any injuries to your teeth or jaws? (Falls, blows, chips, etc.) Yes __No __

Please List _____

Do you have history of nail biting or thumb sucking? Yes __ No ___

If yes, Please explain _____

Have you ever experienced any unfavorable reaction from previous dental care? Yes __ No __

Please Explain: _____

What is your main concern with your dental health? _____

Do you wish to save all teeth possible? Yes ___ No ___ How often do you brush? _____ Floss? _____

Would you like to change the color or look of your teeth? Yes __ No __

Explain _____

Health History

1. Are you presently under the care of a physician for any medical Problem(s)? Yes No
   If yes, please explain: _____
2. Are you currently taking any medications? Yes No
   List all medications:
   _____
   Have you ever been hospitalized or had surgery? Yes No
   If yes, please explain:
   _____
3. Are you allergic to any medication or metals or other? Yes No
   If yes, please list all allergies
   _____
4. Do you have, or have you ever had high blood pressure? Yes No
5. Do you smoke? Yes No If yes, How much daily? _____ Do you use tobacco? Yes No

Medical Information

Patient's Physician _____ City _____ Date last seen _____

Check below if you **HAVE** a history of any of the following:

Heart murmur ___ require premed? ___ Brain Injury ___ Kidney/Liver involvement ___

Rheumatic Fever ___ Diabetic ___ Hep A ____ Hep B ___ Hep C ____ Aids ___ Epilepsy ___

Bleeding Problems ___ Seizures ___ Blood Disorder ___ Reaction to NSAIDS ___ Joint Replacement ___

High Blood Pressure ___ Low Blood Pressure ___ Any other heart conditions/medical conditions ___

Please list _____

None of the above ____

Women only- Any chance you could be pregnant? Yes ___ No ___ Due date _____

Patient/Guardian signature _____ **Date** _____