Perfect Smiles Family Dentistry

500 N. Eastern • Moore, OK 73160
(405) 912-3300

Patient Information

Date:__________ SS#/HIC/Patient ID#:______________

Patient Name______________________________________

Address____

City___________ State______ Zip________________

Sex_____ Age_____ Birth date__________________

Marital Status_____ Adult_____ Minor_____________

Patient Employer/School__________________________

Occupation_______________________________________

Employer/School Phone____________________________

Spouse's name____________________________________

Birth date__________ SS#_________________________

Spouse's Employer________________________________

Who may we thank for referring you?______________

Dental Insurance

Who is responsible for this account?_______________

Relationship to Patient____________________________

Insurance Co.______________________________________

Group #____

Is patient covered by additional insurance? Yes___ No___

Subscriber's Name__________________________________

Birth date______________ SS#______________________

Relationship to Patient____________________________

Insurance Co.______________________________________

Group #____

Phone Numbers

Home(__)____________ Work(__)____________ Cell phone #1(__)__________ Cell phone#2(__)__________

Spouse's Work(__)_________ Best time and place to reach you_____________________________________

Email_______________________________________

IN CASE OF EMERGENCY, CONTACT(Specify someone who does not live in your household)

Name__________________________________ Relationship____

Home Phone(__)_________________________ Work Phone(__)____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with_______________________________ and assign directly to Dr.____________________________all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative_________________________________

Print above signed name_____________________________ Relationship to Patient___________ Date_____________

Dental History

Reason for today's visit________________________ Former Dentist________________________

Date of last dental visit__________ Date of last dental X-rays__________

Place a mark on "yes" or "no" to indicate if you have had any of the following.

Bad breath ___yes ___no
Dry mouth ___yes ___no
Jaw pain ___yes ___no
Bleeding gums ___yes ___no
Grinding teeth ___yes ___no
Sensitive to hot ___yes ___no
Blisters on lips or mouth ___yes ___no
Burning sensation on tongue ___yes ___no
Sensitive to cold ___yes ___no

Do you smoke or use smokeless tobacco?________ How long?__________ Have you quit?_________ How long ago?________

How often do you brush?__________________ How often do you floss?__________________________

Health History

Have you ever taken "fen-phen" , Pondimin, or Redux? When?_________ How long?________ Medical screening done?__________

Do you drink alcohol? ___yes ___no How often?__________ Has your drinking ever caused you problems? ___yes ___no

Have you ever used recreational drugs? ___yes ___no Do you currently use drugs? ___yes ___no

Have you ever had a serious illness or surgery? ____ What and When?________________________________

Have you ever had a blood transfusion? ____ When?________________

Place a mark to indicate if you have had any of the following:

___AIDS/HIV
___Anemia
___Arthritis
___Artificial Heart Valve
___Artificial Joints
___Asthma
___Blood Disease
___Cancer
___Chemotherapy
___Circulatory Problems
___Congenital Heart Disease
___Diabetes
___Emphysema
___Epilepsy
___Fainting of dizziness
___Glaucoma
___Headaches
___Heart Murmur
___Heart Problems
___Hepatitis Type_______
___Herpes
___High Blood Pressure
___Jaundice
___Kidney Disease
___Liver Disease
___Low Blood Pressure ___
___Mitral Valve Prolapse
___Nervous Condition
___Pacemaker
___Psychiatric care
___Radiation treatment
___Respiratory Diseases
___Rheumatic Fever
___Scarlet Fever
___Sinus Trouble
___Skin Rash
___Special Diet
___Stroke
___Thyroid Problems
___Tonsillitis
___Tuberculosis
___Ulcer

Women: Are you pregnant? ____ How many weeks? ____
Are you nursing? _____
Do you take birth control? _____

Do you wear contact lenses? _____

List all Medications you are taking

____
____
____
____
____
____

Pharmacy name______________________
Pharmacy Phone______________________

Allergies

Aspirin ___ Local Anesthetics ____

Barbiturates ___ Penicillin ___

Codeine ___ Sulfa ___

Latex ___ Other________________________________

Consent for Treatment

By my initials, I hereby consent to and authorize any X-rays, examination, and diagnosis by Perfect Smiles Family Dentistry. **INITIALS**_____ By this signature below I am authorizing the above Doctor to perform dental surgery, administer anesthetic and provide the dental treatment explained to me in the treatment plan. This signature also verifies my knowledge and understanding of the treatment to be provided. I understand and it has been explained to me that Dentistry, as in all medical treatments, is not an exact science and therefore results of any treatments performed may vary from patient to patient and cannot be guaranteed. I understand that occasionally, additional surgeries, treatments, or therapies may be required following the initial dental treatment and that I am granting my consent for any and all of these procedures by Perfect Smiles Family Dentistry, hygienists, or assistants. Also, by my signature below I hereby certify the correctness and completeness of the medical history information I have provided above. I also understand that I am responsible for any payment of all fees and costs resulting from my treatment. I also understand that certain complex procedures or medications may require additional consent.

Patient or responsible guardian________________________________ Date________________________

Witness____