

# DENTAL HISTORY

Why did you come to the dentist today? \_\_\_\_\_

Your current dental health is:  Good  Fair  Poor

When was your last cleaning? \_\_\_\_\_

Did you have xrays at that time?  Yes  No

How often do you: Brush \_\_\_\_\_ Floss \_\_\_\_\_

Type of bristles on your toothbrush? (Circle) Hard Medium Soft

Do you do anything else to clean your teeth?  Yes  No

If yes, what? \_\_\_\_\_

Do your gums bleed?  Yes  No

Have you ever had gum disease?  Yes  No

Have you ever had rootplaning or a deeper cleaning?  Yes  No

Does food get caught between your teeth?  Yes  No

Have you ever experienced problems associated with any previous dental work:  Yes  No

Do you or have you ever experienced pain/discomfort in your jaw Joint (TMJ/TMD)?  Yes  No

Are you aware of any clenching or grinding?  Yes  No

Do you have frequent headaches?  Yes  No

Do you have any problems eating certain foods?  Yes  No

If yes, what? \_\_\_\_\_

Are your teeth sensitive to hot, cold or anything else? \_\_\_\_\_

Do you still have your wisdom teeth?  Yes  No

Do you have any mobility in your teeth?  Yes  No

Have you lost any teeth?  Yes  No

If yes, why? \_\_\_\_\_

If you could change one thing about your smile what would it be? \_\_\_\_\_

## For Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Medical History Update:

1. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

2. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

3. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

4. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

5. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

6. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

7. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

8. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

9. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

10. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

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# ADULT HEALTH HISTORY

*Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask us. We will be happy to help.*

Name: \_\_\_\_\_ I prefer to be called \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Home Phone Number: (\_\_\_\_) \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Previous dentist's name? \_\_\_\_\_

## Medical History

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

Phone #: (\_\_\_\_) \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

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

Please explain: \_\_\_\_\_

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

Have you ever had a blood transfusion?  Yes  No

Have you ever taken PhenPhen/Fosamax?  Yes  No

Are you taking any prescriptions or over-the-counter drugs?  Yes  No

If yes, please list each one: \_\_\_\_\_

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin

Y N Barbiturates Y N Jewelry Y N Seasonal

Y N Codeine Y N Latex Y N Sulfa Drugs

Y N Dental Anesthetics Y N Other \_\_\_\_\_

Please list additional drugs that cause allergic reactions: \_\_\_\_\_

**For Women:** Are you taking birth control pills?  Yes  No

Are you pregnant?  Unsure  Yes, week #: \_\_\_\_\_  No

Are you nursing?  Yes  No

Have you experienced the following diseases or medical conditions?

- |                              |                               |                           |
|------------------------------|-------------------------------|---------------------------|
| Y N Abnormal Bleeding        | Y N Emphysema                 | Y N Liver Disease         |
| Y N Alcohol Abuse/Drug Abuse | Y N Epilepsy/Seizures         | Y N Mitral Valve Prolapse |
| Y N Anemia                   | Y N Fainting Spells           | Y N Pacemaker             |
| Y N Arthritis                | Y N Frequent/Severe Headaches | Y N Persistent Cough      |
| Y N Artificial Bones/Joints  | Y N Glaucoma                  | Y N Psychiatric Problems  |
| Y N Artificial Heart Valves  | Y N Hay Fever                 | Y N Radiation Treatment   |
| Y N Asthma                   | Y N Heart Attack              | Y N Rheumatic Fever       |
| Y N Blood Transfusion        | Y N Heart Murmur              | Y N Scarlet Fever         |
| Y N Cancer                   | Y N Heart Surgery             | Y N Sinus Problems        |
| Y N Chemotherapy             | Y N Hepatitis Type _____      | Y N Steroid Therapy       |
| Y N Colitis/Ulcers           | Y N Herpes/Fever Blisters     | Y N Stroke                |
| Y N Congenital Heart Defect  | Y N High/Low Blood Pressure   | Y N Thyroid Problems      |
| Y N Diabetes                 | Y N HIV+/AIDS                 | Y N Tuberculosis (TB)     |
| Y N Difficulty Breathing     | Y N Kidney Problems           | Y N Venereal Disease      |

Please list any hospitalizations or major surgeries in the last five years: \_\_\_\_\_

List any serious medical condition(s) that you have experienced (not listed above): \_\_\_\_\_

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED PORTION.**

**Authorization and Release**

If you have dental insurance, we will prepare and submit your dental claims as a courtesy to you.

**Payment is due in full at the time of treatment**  
unless prior arrangements have been approved.

I acknowledge that I am financially responsible for all changes whether or not they are covered by insurance. I hereby authorize payment directly to Oswego Dental Care of the group insurance benefits otherwise payable to me. I also authorize release of any information including this diagnosis and records of treatment or examination rendered to my insurance company. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses including rebilling & interest charges, missed appointment fees, all collection costs and reasonable attorney fees. Any accounts sent for collections will be assessed an additional \$100 processing fee.

We appreciate your keeping your scheduled appointments. We reserve time & expertise exclusively for you because you are important to us. If you should need to change or cancel your appointment, we kindly ask you give 48 hours notice. Appointments cancelled without 48 hours notice or failed appointments may be assessed a fee of \$25 per half hour of scheduled time.

Payment plans and special arrangements must be made **prior** to treatment & approved by our office manager. Returned checks will be charged a flat rate of \$25.00 per check per incident. Balances older than 60 days from the date of service, regardless of insurance, may be subject to the following interest charges. Interest is calculated at a rate of 1.5% per month (or 18% annually or a \$5.00 rebilling fee (whichever is greater)) and applied monthly to unpaid account balances.

For your convenience, we accept most major credit cards. We also offer additional payment plans through an outside financing group. If you would like more information or have any questions, please let us know. We are happy to help.

**Name** (Please print): \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



*Oswego Dental Care*  
*Where you find your smile*

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# WELCOME

*Thank you in advance for your coming to see us today. In order for us to better serve you, please take a few moments to complete this entire form. At Oswego Dental Care, we are committed to keeping your private healthcare information confidential.*

**Today's Date:** \_\_\_\_\_

**Person Financially Responsible for Account (parent's name if minor):**

Name: \_\_\_\_\_  
Last First Mi Mr Mrs Ms Dr

I prefer to be called: \_\_\_\_\_

Male  Female Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Apt/Condo #

City State Zip

Single  Married  Divorced  Widowed  Separated

Home Phone: (\_\_\_\_) \_\_\_\_\_ Pager: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

**Employer:**

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

Length of employment: \_\_\_\_\_

Occupation: \_\_\_\_\_

When are the best times to reach you? \_\_\_\_\_ am \_\_\_\_\_ pm

Whom may we thank for referring you? \_\_\_\_\_

**Second Person Responsible for Account/Spouse:**

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Employer: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

**Primary Dental Insurance**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone: (\_\_\_\_) \_\_\_\_\_

Group Number (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Relationship to Patient: \_\_\_\_\_

Insured's SS #(required): \_\_\_\_\_

Insured Insurance ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

**Secondary Dental Insurance**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone: (\_\_\_\_) \_\_\_\_\_

Group Number (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Relationship: \_\_\_\_\_

Insured's SS #: (required) \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

**In the event of any emergency, whom should we contact?**

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
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