Thomas Dental Care

12406 East 86th Street North
Owasso, Oklahoma 74055
(918)376-2700

PATIENT INFORMATION

PATIENT NAME: FIRST_____ MI_____ LAST_____

ADDRESS_____ CITY_____ STATE _____ ZIP_____

HOME PHONE _____ WORK PHONE _____ CELL PHONE_____

DOB_____ SSN_____ EMPLOYER_____

NAME OF PERSON COMPLETING THIS FORM (IF DIFFERENT FROM PATIENT) _____

RELATION TO PATIENT_____EMAIL_____

Emergency Contact_____ Phone_____ Relation_____

INSURANCE POLICY HOLDER INFORMATION

INSURED'S NAME: FIRST_____ MI_____ LAST_____

DOB:_____ SSN_____ RELATION TO PATIENT_____

INSURANCE COMPANY_____ PHONE_____

EMPLOYER_____

DENTAL HEALTH INFORMATION

THANK YOU FOR PROVIDING THE FOLLOWING IMPORTANT INFORMATION THAT WILL HELP US TO SERVE YOU BETTER.

	YES	NO
DOES DENTAL TREATMENT MAKE YOU NERVOUS?	☐	☐
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING PROBLEMS?		
SENSITIVITY TO HOT COLD OR SWEETS?	☐	☐
BLEEDING GUMS	☐	☐
BAD BREATH	☐	☐
SORENESS IN JAW JOINT	☐	☐
GRINDING OF TEETH	☐	☐
SNORING	☐	☐
DO YOU THINK YOUR DENTAL HEALTH AFFECTS YOUR OVERALL HEALTH?	☐	☐
DO YOU SMOKE OR USE TOBACCO IN ANY FORM?	☐	☐
DO YOU DRINK COFFEE OR TEA?		
IF I COULD CHANGE MY SMILE, I WOULD MAKE MY TEETH:		
WHITER/BRIGHTER	☐	☐
STRAIGHTER	☐	☐
CLOSE SPACE	☐	☐
REPLACE BLACK MERCURY FILLINGS WITH TOOTH COLORED RESTORATIONS	☐	☐
REPAIR CHIPPED TEETH	☐	☐
REPLACE MISSING TEETH	☐	☐

DATE OF LAST CLEANING? _____

HOW OFTEN DO YOU BRUSH? _____ FLOSS?_____

WHAT IS THE MOST IMPORTANT THING TO YOU ABOUT YOUR FUTURE SMILE AND DENTAL HEALTH?_____

WHAT IS THE MOST IMPORTANT THING TO YOU ABOUT YOUR DENTAL VISIT TODAY?_____

_____

HAVE YOU EVER HAD INTRAVENOUS SEDATION OR GENERAL ANESTHESIA? ..... ☐ ☐

GENERAL HEALTH INFORMATION

	YES	NO
ARE YOU IN GOOD HEALTH?	☐	☐
HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?	☐	☐

DATE OF LAST CHECK-UP BY PHYSICIAN_____

ARE YOU CURRENTLY UNDER A PHYSICIANS' CARE? ..... ☐ ☐

IF SO, FOR WHAT?_____

PHYSICIANS NAME _____ PHONE_____

HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS, OR HOSPITALIZATIONS? ..... ☐ ☐

IF SO, DESCRIBE AND GIVE APPROXIMATE DATES_____

_____

	YES	NO
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:		
HEART DISEASE DETECTED AT BIRTH?	☐	☐
RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE?	☐	☐
CARDIOVASCULAR DISEASE (CHEST PAIN, HEART ATTACK, CORONARY ARTERY DISEASE, HIGH BLOOD PRESSURE, STROKE, PALPITATIONS, HEART SURGERY, ANGIOPLASTY, PACEMAKER)?	☐	☐
LUNG DISEASE (ASTHMA, EMPHYSEMA, CHRONIC COUGH, BRONCHITIS, PNEUMONIA, TB, SHORTNESS OF BREATH, SEVERE COUGH)?	☐	☐
NEUROLOGICAL DISORDERS (SEIZURE, EPILEPSY, FAINTING, DIZZINESS, NERVOUS DISORDER)?	☐	☐
BLOOD DISEASE (BLEEDING DISORDER, ANEMIA, BLOOD TRANSFUSION, DO YOU BRUISE EASILY)?	☐	☐
LIVER DISEASE (JAUNDICE, HEPATITIS)?	☐	☐
KIDNEY DISEASE?	☐	☐
DIABETES?	☐	☐
THYROID DISEASE (HYPOTHYROIDISM, TUMOR)?	☐	☐
ARTHRITIS?	☐	☐
STOMACH ULCERS OR INTESTINAL PROBLEMS?	☐	☐
GLAUCOMA?	☐	☐
FREQUENT OR RECURRING MOUTH SORES?	☐	☐
IMPLANTS/ARTIFICIAL JOINTS (HEART VALVE, HIP, KNEE)?.....	☐	☐
RADIATION (X-RAY TREATMENT FOR CANCER) IN HEAD OR NECK REGION? ...	☐	☐
NOISES IN JAW JOINT, PAIN NEAR EAR WHEN CHEWING, DO YOU GRIND OR CLENCH YOUR TEETH?	☐	☐
SINUS OR NASAL PROBLEMS?	☐	☐
ANY DISEASE, DRUG, OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM?	☐	☐
INFECTIONS OF ANY KIND?	☐	☐
ARE YOU USING ANY OF THE FOLLOWING MEDICATIONS?		
ANTIBIOTICS?	☐	☐
ANTICOAGULANTS (BLOOD THINNERS)?	☐	☐
THYROID MEDICATIONS?	☐	☐
ANTIHISTAMINES, DECONGESTANTS?	☐	☐
HIGH BLOOD PRESSURE OR HEART?	☐	☐
STEROIDS?	☐	☐
TRANQUILIZERS, ANTIDEPRESSANTS?	☐	☐
STOMACH OR GI MEDICATIONS?	☐	☐

CHOLESTEROL REDUCING DRUGS? ..... ☐ ☐
ASPIRIN, IBUPROFEN, NSAIDS OR ANTI-INFLAMMATORY DRUGS, NARCOTICS, OPIOIDS OR OTHER PAIN RELIEVERS? ..... ☐ ☐
WEIGHT REDUCTION PILLS OR DIET AIDS (OVER THE COUNTER OR NATURAL)? ☐ ☐
VITAMINS, NATURAL REMEDIES (GINKO BILOBA, EPHEDRA, GINSENG, ETC)? ☐ ☐
MARIJUANA, COCAINE OR OTHER "RECREATIONAL" DRUGS? ..... ☐ ☐
ANY OTHER REGULAR MEDICATIONS, PILLS, SUPPLEMENTS OR DRUGS? ..... ☐ ☐

PLEASE LIST ALL CURRENT MEDICATIONS:

_____

_____

_____

ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD AN ALLERGIC REACTION FROM ANY OF THE FOLLOWING: PLEASE CHECK AND CIRCLE	YES	NO
LOCAL ANESTHETIC (NOVOCAIN-LIKE DRUGS)?	☐	☐
PENICILLIN, AMOXICILLIN, CEPHALOSPORIN?	☐	☐
OTHER ANTIBIOTICS?	☐	☐
BARBITUATES, SEDATIVES?	☐	☐
ASPIRIN, IBUPROPHEN, NSAIDS OR OTHER PAIN MEDICATIONS?	☐	☐
CODEINE, OTHER NARCOTICS, OR OPIOIDS?	☐	☐
LATEX?	☐	☐
PLEASE LIST ANY OTHER ALLERGIES: _____		
DO YOU HAVE HAY FEVER, FREQUENT SKIN RASHES, ETC?.....	☐	☐
DO YOU USE ALCOHOL? DRINKS PER DAY_____	☐	☐
DO YOU SMOKE?	☐	☐
WHAT PRODUCT AND HOW MUCH PER DAY?_____ HOW LONG_____		
DO YOU USE SPIT TOBACCO?	☐	☐
DO YOU HAVE ANY OTHER DISEASES, CONDITIONS, OR PROBLEMS NOT LISTED THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT?	☐	☐
WOMEN:		
ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐
ARE YOU PREGNANT, TRYING TO BECOME PREGNANT, OR IS THERE ANY POSSIBILITY OF BEING PREGNANT?	☐	☐
ARE YOU BREASTFEEDING?	☐	☐
ARE YOU TAKING HORMONAL REPLACEMENTS?	☐	☐

I HEREBY AUTHORIZE DIRECT PAYMENT OF MY INSURANCE BENEFITS TO THOMAS DENTAL CARE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH MY DENTAL TREATMENT. I HEREBY AUTHORIZE THOMAS DENTAL CARE TO ADMINISTER SUCH MEDICATION AND PERFORM SUCH DIAGNOSTIC AND THERAPEUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND REALIZE THAT INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT ON MY TREATMENT. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.

_____ _____ _____

DATE **SIGNATURE OF PERSON COMPLETING FORM** **DR'S INITIALS**

PLEASE SIGN & DATE BELOW

HIPPA PATIENT ACKNOWLEDGEMENT

I HAVE READ THOMAS DENTAL CARE'S NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGE THAT I HAVE RECEIVED A COPY.

PATIENT NAME: _____

SIGNATURE: (of parent/guardian if under 18) _____

DATE: _____