OAKS DENTAL GROUP

PATIENT REGISTRATION

Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Cell Phone: _____ Home Phone: _____

SS#/SIN: _____ Birthdate: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T./P.T Name of School: _____ City: _____ State: _____

Patient's or Parent/Guardian's Employer: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's/Guardian's Name: _____ Employer: _____ Work Phone: _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency: _____ Phone: _____

Responsible Party:

Name of Person Responsible for this Account: _____ Relationship: _____

Address: _____ Home Phone: _____

Driver's License #: _____ Birthdate: _____ SS#/SIN: _____

Employer: _____ Work Phone: _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information:

Name of Insured: _____ Relationship to patient: _____

Birthdate: _____ SS#/SIN: _____ Date Employed: _____

Name of employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State/Zip: _____

Primary Insurance:

Insurance Company: _____ Tel #: _____

Insurance Address: _____ City: _____ State/Zip: _____

Subscriber ID #: _____ Group #: _____

Secondary Insurance:

Name of Insured: _____ Relationship to patient: _____

Birthdate: _____ SS#/SIN: _____ Date Employed: _____

Name of employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State/Zip: _____

Insurance Company: _____ Tel #: _____

Insurance Address: _____ City: _____ State/Zip: _____

Subscriber ID #: _____ Group #: _____

OAKS DENTAL GROUP

MEDICAL HISTORY

Patients Name: _____ **Date of Birth:** _____

Physicians Name: _____ **Phone Number:** _____

Address: _____ **Date of last Physical Exam:** _____

Reason for this visit: _____

When was your last dental visit: _____ What was done then? _____

How often did you visit the dentist before then? _____

Previous Dentist (Name & Location): _____

Have you had a complete series of dental films (x-rays) taken when/where? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Is your drinking water fluorinated? _____

Do your gums bleed while brushing or flossing?	☐ Yes ☐ No	Do you have frequent headaches?	☐ Yes ☐ No
Are your teeth sensitive to hot or cold liquids/foods?	☐ Yes ☐ No	Do you clench or grind your teeth?	☐ Yes ☐ No
Are your teeth sensitive to sweet or sour liquids/foods?	☐ Yes ☐ No	Do you bite your lips or cheeks frequently?	☐ Yes ☐ No
Do you feel pain to any of your teeth?	☐ Yes ☐ No	Have you noticed any loosening of your teeth?	☐ Yes ☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes ☐ No	Does food tend to become caught between your teeth?	☐ Yes ☐ No
Have you had any head, neck or jaw injuries?	☐ Yes ☐ No	Have you ever had periodontal treatment? (Gums)	☐ Yes ☐ No
Have you ever experienced any of the following problems in your jaw?	☐ Yes ☐ No	Ever worn a bite plate or other appliance?	☐ Yes ☐ No
Clicking?	☐ Yes ☐ No	Have you ever had any difficult extractions in the past?	☐ Yes ☐ No
Pain? (Joint, Ear, Side of face)	☐ Yes ☐ No	Have you ever had prolonged bleeding following extractions?	☐ Yes ☐ No
Difficulty in opening or closing?	☐ Yes ☐ No	Do you wear dentures or partials? If yes, date of placement: _____	☐ Yes ☐ No
Difficulty in chewing?	☐ Yes ☐ No	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐ Yes ☐ No

If you could change <u>anything</u> about your smile, what would you change?

_____

Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date: _____

Signature of Patient or Parent/Guardian if Minor

OAKS DENTAL GROUP

MEDICAL HISTORY

Are you in good health?	☐ Yes ☐ No	Have you taken Fen-Phen/Redux?	☐ Yes ☐ No
Have there been any changes in your general health within the past year?	☐ Yes ☐ No	Have you ever taken Fosamax, Boniva, Actonel or and cancer medications containing bisphosphates?	☐ Yes ☐ No
Are you now under the care of a Physician?	☐ Yes ☐ No	Have you ever taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐ Yes ☐ No
Have you had abnormal bleeding?	☐ Yes ☐ No	Do you use tobacco?	☐ Yes ☐ No
Do you bruise easily?	☐ Yes ☐ No	Do you or have you used controlled substances?	☐ Yes ☐ No
Have you ever required a blood transfusion?	☐ Yes ☐ No	Are you wearing contact lenses?	☐ Yes ☐ No
Have you had a recent weight loss?	☐ Yes ☐ No	Do you have a persistent cough or throat clearing not associated with a known illness? (Lasting more than 3 weeks)	☐ Yes ☐ No
Do you have any disease, condition or problem not listed above that you think I should know about?	☐ Yes ☐ No		

Have you been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No
If yes, please explain: _____

Are you taking any medicine(s) including non-prescription medicine? ☐ Yes ☐ No
If yes, please explain: _____

Women Only:
Are you pregnant or think you may be pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

Are you Allergic to or have you had reactions to:

☐ **Local Anesthetics like Novocain** ☐ **Penicillin or other Antibiotics** ☐ **Sulfa Drugs** ☐ **Aspirin** ☐ **Iodine**
☐ **Barbiturates, Sedatives or Sleeping pills** ☐ **Any Metals (E.G., Nickel, Mercury, Etc.)** LATEX ☐
☐ **Other (Please List):** _____

Do you have or have you ever had the following:

Rheumatic Heart Disease.....	☐ Yes ☐ No	Liver Disease....	☐ Yes ☐ No	Kidney Trouble	☐ Yes ☐ No
Rheumatic Fever....	☐ Yes ☐ No	Stroke....	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Scarlet Fever....	☐ Yes ☐ No	Sinus Trouble....	☐ Yes ☐ No	Persistent Cough	☐ Yes ☐ No
Heart Defect or Heart Murmur....	☐ Yes ☐ No	Lung or Breathing Problems....	☐ Yes ☐ No	Cough that produces blood	☐ Yes ☐ No
Heart Trouble, Heart Attack, or Angina...	☐ Yes ☐ No	Asthma or Hay Fever...	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No
Chest Pain...	☐ Yes ☐ No	Sinus Trouble....	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Shortness of breath..	☐ Yes ☐ No	Lung or Breathing Problems.....	☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No
Pacemaker...	☐ Yes ☐ No	Asthma or Hay Fever...	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Heart Surgery...	☐ Yes ☐ No	Hives or Skin Rash....	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
High/Low Blood Pressure...	☐ Yes ☐ No	Fainting of Dizzy Spells	☐ Yes ☐ No	Nervousness	☐ Yes ☐ No
Congenital Heart Problems...	☐ Yes ☐ No	Diabetes....	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Swelling of feet, ankles, hands...	☐ Yes ☐ No	Aids or HIV Infection....	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Hepatitis...	☐ Yes ☐ No	Thyroid Problems.....	☐ Yes ☐ No	Mental Health Care	☐ Yes ☐ No
Jaundice...	☐ Yes ☐ No	Allergies....	☐ Yes ☐ No	Back Problems	☐ Yes ☐ No
Cortisone Treatment	☐ Yes ☐ No	Arthritis or Rheumatism	☐ Yes ☐ No	Chemical Dependency	☐ Yes ☐ No
		Joint Replacement...	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
		Implant.....	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No
		Stomach Ulcer	☐ Yes ☐ No	Eating Disorders	☐ Yes ☐ No
		Cold Sores/Blisters	☐ Yes ☐ No		

Oaks Dental Group
1105 E. Foster Rd., Suite C
Santa Maria, CA 93455

Financial/HIPPA/Patient Release

Thank you for choosing Oaks Dental Group. We appreciate the opportunity to care for you and your family's dental needs. We are pleased to help you with your insurance (if applicable); however, you are ultimately responsible for payment of your bill. The following information is provided to answer questions and avoid confusion regarding payment for dental services.

Authorization to release information: I hereby authorize the release of my Protected Health Information (PHI) acquired in the course of my examination or treatment (typically x-rays, cut could include health history, diagnosis, treatment or payment records), vis electronic transmission, including emails with out special encryption, to my insurance company to secure payment for services or to other dental providers required to participate in my care, I further authorize the below named parties have access to my PHI and do acknowledge any party providing insurance coverage or financial responsibility will have access to my PHI.

Please circle: Spouse Parent Child Other_____

Signature of Patient/Legal Guardian:_____ **Date:**_____

Acknowledgement of receipt of Notice of Privacy Practice AND Notice of Material: I hereby acknowledge that the Notice of Privacy Practices and Material Data is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me

Signature of Patient/Legal Guardian:_____**Date:**_____

Financial Responsibility:

For patients ***with dental benefits***: As a courtesy, our office will file your claim with your insurance company and work with the company to provide the necessary information to maximize your benefits. Any amount not received from your insurance company is your responsibility. **All co-pays are due on day of treatment.**

For patients ***without dental benefits***: If you do not have dental insurance, you will be responsible for the full cost of your treatment. **Payment for services is due at the time of treatment.**

We accept cash, personal checks, and the following credit cards: Visa, MasterCard, American Express and Discover. We also offer Care Credit.

We are pleased to offer a 5% savings to patients with a treatment plan over $500. The treatment must be paid in full on the day of service by cash or check.

Appointments missed or cancelled less than 48 hours in advance will be charged a $75 fee.

Signature of Patient/Legal Guardian:_____**Date:**_____