Oceans Dental, P.C.

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1. About You

Today's Date: ________________

Name: ____
Last First MI Mr Mrs Ms Dr

I prefer to be called: ____________________ ❒ Male ❒ Female

Birthdate: ___/___/___ Age: _____ SS#: ________________

Home Address: ____________________________________

____
City State Zip

❒ Single ❒ Married ❒ Divorced/Separated ❒ Widowed

Home Ph: (_____) ______________ Cell / Other: ___________

Work Ph: (_____) ______________ Ext. _____ DL # _________

Email Address: ____________________________________

Preferred method of communication: ________________

Okay to accept text reminder: Y N Okay to recieve email: Y N
(This is important because it helps us send appointment reminders)

Employer: ____

Full Time ❒ Part Time ❒ Student ❒ Retired ❒

Employer's Address: ________________________________

____
City State Zip

How long there? ________ Occupation: ________________

Whom may we thank for referring you? ________________

Previous / Present Dentist: __________________________

Last Visit to Dentist: ______________________________

Person Responsible for Account ______________________

Emergency Contact: ________________________________

Phone: (______) ____________________________________

2. Spouse Information

Spouse Name: ______________________________________

Employer: ____

Birthdate: ___/___/___ Age: _____ SS#: ________________

Work Ph: (_____) ______________ Ext. _____ DL # _________

3. Dental Insurance

Please provide copies of all insurance cards front and back.

Primary Insurance

Do you have dental insurance? ❒ Yes ❒ No

Subscribers Name: __________________________________

Birthdate: ____/____/____ SS#: ______________________

Relationship: ______________________________________

Employer: ____

Insurance Co. Name: ________________________________

Insurance Co. Address: ______________________________

Phone #: ____

Subscribers ID #: ___________________________________

Group #: ____

Payor ID# (if known) ________________________________

Secondary Insurance

Subscribers Name: __________________________________

Birthdate: ____/____/____ SS#: ______________________

Relationship: ______________________________________

Employer: ____

Insurance Co. Name: ________________________________

Insurance Co. Address: ______________________________

Phone #: ____

Subscribers ID #: ___________________________________

Group #: ____

Payor ID# (if known) ________________________________

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Oceans Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

____
Signature Date

Relationship to Patient: ____________________________

4. Medical History

Name: ______________________________
Last First MI Mr Mrs Ms Dr

Birthdate: ____/____/____

Do you have a personal physician? ❒ No ❒ Yes

Physician's Name: ______________________________

Phone #: (____) ____________Date of Last Visit: ____________

Your current physical health is: ❒ Good ❒ Fair ❒ Poor

Are you currently under the care of a physician: ❒ No ❒ Yes

Please explain ______________________________

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

Are you taking any prescription / over-the-counter drugs?

❒ No ❒ Yes

Please list each one (if you require more space, feel free to provide a copy of list separately): ______________________________

____

Have you had a joint replacement or any other procedure that requires an antibiotic prior to dental appointments?

❒ No ❒ Yes

If yes, please list procedure: ______________________________

When procedure was done: ______________________________

Prescribing Physician: ______________________________

Phone # (_____)- ______________________________

Duration of premedication ______________________________

Are you currently taking or have taken medication previously for Osteoporosis? ❒ No ❒ Yes

Are you pregnant? ❒ No ❒ Yes Week #: __________

Are you nursing? ❒ No ❒ Yes

Treating Physician: ______________________________

Have you ever had any of the following diseases or medical problems:

Y N Abnormal Bleeding / Hemophilia
Y N Addison's Disease
Y N AIDS
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Asthma
Y N Auto Immune Disease
Explain: ____________________
Y N Cancer Date: __________
Type: ____________________
Y N Chemotherapy/other treatment
Date: __________
Y N Clinical Depression
Y N Anxiety (Other than mild dental apprehension)
Y N Diabetes Type 1 or Type 2
Y N Difficulty Breathing
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Healing Complications
Y N Heart Attack
Y N Heart Surgery
Explain: ____________________
Y N Heart Disease
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N HIV +
Y N Hospitalized for Any Reason
Explain: ____________________
Y N Joint Replacement
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Pacemaker
Y N Psychological Disorders
Explain: ____________________
Y N Radiation Treatment
Y N Respiratory Disease
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Sinus Problems
Y N Stroke
Y N Tuberculosis (TB)
Y N Ulcers
Y N COVID-19 Date: __________

Please list any serious medical condition(s) that you have ever had:

____

____

____

Are you allergic to any of the following?: Y N Sulfa

Y N Aspirin Y N Erythromycin Y N Penicillin
Y N Codeine Y N Jewelry/Metals Y N Tetracycline
Y N Dental Anesthetics Y N Latex Y N Other

Please list any other drugs/materials that you are allergic to: ___

____

____

5. Dental History

Why have you come to the dentist today? ____________________

____

Do you have any dental concerns? ❒ No ❒ Yes

If yes, please explain ______________________________

____

Are you currently in pain? ______________ ❒ No ❒ Yes

Your current dental health is: ❒ Good ❒ Fair ❒ Poor

Have you ever had a serious / difficult problem associated with any previous dental work? ❒ No ❒ Yes

Please explain: ______________________________

____

Have you ever had periodontal disease? (gum disease)

❒ No ❒ Yes

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

Are your teeth sensitive to heat, cold, or anything else? _______

____

Do you have any loose teeth? ❒ No ❒ Yes

Do you still have wisdom teeth? ❒ No ❒ Yes

Do you currently wear a partial or full denture? ❒ No ❒ Yes

Do you currently have any dental implants? ❒ No ❒ Yes

Have you had orthodontic treatment? ❒ No ❒ Yes

Orthodontist: ____________________

Is there anything you would like to discuss in private with the Dr. regarding treament/oral concerns? ❒ No ❒ Yes

I understand that the information I have given today is correct to the best of my knowledge. I also 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 medical 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

Relationship to Patient: ______________________________