Lone Oak Dental

Patient Registration

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Email: _____

Address: _____ Apt: _____ City, State, Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Ext: _____

Cell Phone: ( ) _____ Sex: ○ Male ○ Female

Birth Date: _____ SSN: _____ Drivers Lic: _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed ○ Domestic Partner

Employment Status: ○ Full Time ○ Part Time ○ Retired ○ Employer: _____

Student Status: ○ Full Time ○ Part Time Name of School/College: _____

Preferred contact method: ○ Phone ○ Text ○ Email

Spouse /Parent/Guardian: _____

Person to contact in case of emergency: _____ Phone: ( ) _____

How did you hear about us? _____

Responsible Party *(if someone other than the patient)*

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Apt: _____ City, State, Zip: _____

Responsible Party is also:

○ Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary policy Holder

Primary Insurance Information

Name of Insured: _____

Relationship to Patient: _____

SSN/ID: _____ DOB: _____

Policy ID: _____ Group #: _____

Insurance Company: _____

Phone: ( ) _____

Address: _____

City, State, Zip: _____

Employer: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Patient: _____

SSN/ID: _____ DOB: _____

Policy ID: _____ Group #: _____

Insurance Company: _____

Phone: ( ) _____

Address: _____

City, State, Zip: _____

Employer: _____

Medicaid ID: _____ Employer ID: _____ Pref Pharmacy: _____

Carrier ID: _____ Care Credit: _____

Lone Oak Dental

Medical History

Do you have a personal physician? ○ Yes ○ No Physician's Name: _____

Physician's/ Clinic Phone: ( ) _____ Date of last visit: _____

Your current physical health is: ○ Good ○ Fair ○ Poor _____

Do you use tobacco in any form? ○ Yes ○ No

Do you use controlled Substances? ○ Yes ○ No

If so, please explain: _____

_____

Have you had any metal rods, pins or implants placed? ○ Yes ○ No

Are you taking any medications? ○ Yes ○ No

Please list each one: _____

_____

_____

Are you taking any Bisphosphonates? *(i.e. Boniva, Fosamax, Reclast)* _____

Are you taking any blood thinners? *(i.e Coumadin, Aspirin, Plavix)* _____

Have you ever had any surgical procedures? ○ Yes ○ No

Please list each one: _____

_____

Do you have, or have you had, any of the following? *(check any that apply)*

- ○ Abnormal Bleeding
- ○ Alcohol Abuse
- ○ Allergies
- ○ Alzheimer's
- ○ Anemia
- ○ Angina Pectoris
- ○ Arthritis
- ○ Artificial Heart Valve
- ○ Asthma
- ○ Blood Transfusion
- ○ Cancer
- ○ Chemotherapy
- ○ Colitis
- ○ Congenital Heart Defect
- ○ Diabetes
- ○ Dialysis
- ○ Difficulty Breathing
- ○ Drug Abuse
- ○ Emphysema
- ○ Epilepsy
- ○ Facial Surgery
- ○ Fainting Spells
- ○ Fever Blisters
- ○ Frequent Headaches
- ○ Glaucoma
- ○ HIV+ AIDS
- ○ Heart Attack
- ○ Heart Murmur
- ○ Heart Surgery
- ○ Hemophilia
- ○ Hepatitis B
- ○ Hepatitis C
- ○ High Blood Pressure
- ○ Infection *(MRSA/VRE)*
- ○ Joint Replacement
- ○ Kidney Problems
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Mitral Valve Prolapse
- ○ Pace Maker
- ○ Psychiatric Problems
- ○ Radiation Therapy
- ○ Rheumatic Fever
- ○ Seizures
- ○ Sexually Transmitted Infection
- ○ Shingles
- ○ Sickle Cell Disease
- ○ Sinus Problems
- ○ Stroke
- ○ Thyroid Problems
- ○ Tuberculosis
- ○ Ulcers
- ○ Other: _____

Do you have any Allergies? *(Check any that apply)*

- ○ Acrylic
- ○ Aspirin
- ○ Codeine
- ○ Dental Anesthetics
- ○ Jewelry
- ○ Latex
- ○ Metals
- ○ Penicillin
- ○ Tetracycline
- ○ Other: _____

Medical History (Continued)

If Female, Please Answer:

Are you taking Birth Control Pills? ○ Yes ○ No

Are you pregnant? ○ Yes ○ No If so, # of Weeks: _____ Are you nursing? ○ Yes ○ No

Name of the nearest relative not living with you: _____ Relationship: _____

Address: _____ Phone: ( ) _____

Dental History

How may we help you today? _____

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

Are you currently in pain? ○ Yes ○ No

Do you require antibiotics before dental treatment? ○ Yes ○ No

Have you ever had gum treatment? ○ Yes ○ No

Do your gums bleed? ○ Yes ○ No

Do you now or have you had any pain/discomfort in your jaw joint? *(TMJ)* ○ Yes ○ No

Are you under stress? *(new job,moving,relationships)* ○ Yes ○ No

Is there anything you would like to change about your smile? ○ Yes ○ No

Explain: _____

Are you happy with the color of your teeth? ○ Yes ○ No

How many times a do you: floss/week? _____ brush/day? _____

Are your teeth sensitive to heat, cold or anything else? ○ Yes ○ No

Have you lost any teeth? ○ Yes ○ No

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

Have you ever had any unfavorable dental experiences? ○ Yes ○ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

Previous dentist's name: _____ City and State: _____

How can we accommodate you better during your dental visit? _____

_____

Here at Lone Oak Dental we offer a wide variety of services to enhance and keep your smile beautiful.

Please circle any services below you would like our friendly staff to discuss with you during your visit:

Tooth Whitening	Smile Makeover	
Veneers	Bonding	Partials/Dentures
Invisalign	Sealants	Night/Sport Guards
Traditional Orthodontics	Implants	Sleep Apnea Appliances

Lone Oak Dental

Signature Page

Medical and Dental History

I understand that the information that 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.

Signature: _____ Date: _____

Print Name: _____

Notice of Privacy Practices

I have read a copy of Lone Oak Dental's Notice of Privacy Practices. I consent for use and disclosure of any health information needed to carry out treatment and obtain payment.

Signature: _____ Date: _____

Print Name: _____

Assignment of Benefit and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Lone Oak Dental 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 hereby authorize Lone Oak Dental to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship: _____ Date: _____

Print Name: _____