

Broken Arrow Family Dentistry *** 2011 ***

Thank You for Choosing Our Practice for Your Dental Care!

PATIENT:

Name: _____ Nickname: _____

Address: _____

City, State, Zip: _____

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

Cell Phone: (____) _____ Email: _____

Please Circle Your Preferred Method of Contact for Appointment Reminders (above).

Birthdate: _____ Social Security Number: _____ Male ___ Female ___

Employer _____ Occupation _____

RESPONSIBLE PARTY: Please complete any information that is different than that shown for the patient.

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

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

Cell Phone: (____) _____ Email: _____

Birthdate: _____ Social Security Number: _____ Male ___ Female ___

Employer _____ Occupation _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

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

Cell Phone: (____) _____ Email: _____

PRIMARY Policy Holder Name: _____ Birthdate: _____

Relationship: _____ SS#: _____ ID#: _____

Employer: _____ Phone: (____) _____

Group #: _____ Group Name: _____

Insurance Co: _____ Phone: (____) _____

SECOND Policy Holder Name: _____ Birthdate: _____

Relationship: _____ SS#: _____ ID#: _____

Employer: _____ Phone: (____) _____

Group #: _____ Group Name: _____

Insurance Co: _____ Phone: (____) _____

REFERRAL: Please tell us whom we may thank, or recognize for referring you to our practice.

Name: _____ Phone Book: _____ Other: _____

I have read the BAFD Financial Policy and agree to the terms therein, including paying the estimated patient's share at the time of service. I understand that a monthly service charge of 1½ % (18% annually) may be added to any balance not paid within 30 days.

Signature of Patient or Guardian

Relationship to Patient

Date



BROKEN ARROW FAMILY DENTISTRY

Thank You For Choosing Our Office!

NAME _____ Date of Birth _____

MEDICAL HISTORY

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

- | | | |
|--|-----|----|
| 1. Are you in good health? | Yes | No |
| 2. Has there been any change in your general health within the past year? | Yes | No |
| 3. My last physical examination was on _____ | | |
| 4. Are you now under the care of a physician? | Yes | No |
| If so, what is the condition being treated? _____ | | |
| 5. The name and address of my physician is _____ | | |
| _____ | | |
| _____ | | |
| 6. Have you had any serious illness or operation? | Yes | No |
| If so, what was the illness or operation? | | |
| 7. Have you been hospitalized or had a serious illness within the past five (5) years? | Yes | No |
| If so, what was the problem? _____ | | |
| 8. Do you have or have you had any of the following diseases or problems? | | |
| a. Damaged heart valves or artificial heart valves, including heart murmur, mitral valve prolapse | Yes | No |
| b. Congenital heart lesions | Yes | No |
| c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) | Yes | No |
| 1. Do you have pain in the chest upon exertion? | Yes | No |
| 2. Are you ever short of breath after mild exercise? | Yes | No |
| 3. Do your ankles swell? | Yes | No |
| 4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? | Yes | No |
| 5. Do you have a cardiac pacemaker? | Yes | No |
| d. Allergy | Yes | No |
| e. Sinus trouble | Yes | No |
| f. Asthma or hay fever | Yes | No |
| g. Hives or a skin rash | Yes | No |
| h. Fainting spells or seizures | Yes | No |
| i. Diabetes | Yes | No |
| 1. Do you have to urinate (pass water) more than six times a day? | Yes | No |
| 2. Are you thirsty much of the time? | Yes | No |
| 3. Does your mouth frequently become dry? | Yes | No |
| j. Hepatitis, jaundice or liver disease | Yes | No |
| k. Arthritis | Yes | No |
| l. Inflammatory rheumatism (painful swollen joints) | Yes | No |
| m. Stomach ulcers | Yes | No |
| n. Kidney trouble | Yes | No |
| o. Tuberculosis | Yes | No |
| p. Do you have a persistent cough or cough up blood? | Yes | No |
| q. Low blood pressure | Yes | No |
| r. Venereal disease | Yes | No |
| s. Epilepsy | Yes | No |
| t. Psychiatric problems | Yes | No |
| u. Cancer | Yes | No |
| v. AIDS or other immunosuppressive disorders | Yes | No |
| w. Other | Yes | No |