Welcome

Thank you for selecting our dental health team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information *(Confidential)*

Date_______________

Name ____ Birth Date ______________________

Social Security ________________________ Gender: Male ❑ Female Check appropriate box: ❑ Minor ❑ Single ❑ Married

Address____

City____ State ________ Zip ___________________________

Home Phone ______________________ Work Phone ______________________ Cell ______________________

Email ____

Whom may we thank for referring you to us? ____

Person to contact in case of emergency? ____

Responsible Party

Name of person responsible for this account ____

Address____

City____ State ________ Zip ___________________________

Email: ____

Work Phone ______________________ Cell ______________________

For your convenience, we accept the following methods of payment. Please check the option you prefer. Payment is due in full for each appointment. ❑ Cash ❑ Personal Check ❑ VISA ❑ MasterCard ❑ American Express ❑ Discover ❑ CareCredit®

Insurance Information

Subscriber ____

Relationship to Patient ______________________Birth Date______________________ Plan Type: ❑ Family ❑ Individual

ID Number ______________________________________ Group #_________________________________

Subscriber's Employer ____

Insurance Company ____

Insurance Company Address ____

Work Phone ______________________ Cell ______________________

The above is the insurance coverage verified for the above named patient. Dental Arts as a courtesy will file insurance claims to the insurance company. The insured or patient authorizes the insurance company to pay the provider directly. All deductibles, co-payments, and denied claims will be the total responsibility of the patient. Please feel free to contact any Dental Arts' representative with any questions.

Insured or Patient Signature Date

____ _______________

Riverwalk, 290 Merrimack St., S. Lawrence, MA 01843 | Telephone **978-682-5500** | Fax **978-682-5505** | **info@oasisdentalsolutions.com**

OASIS Dental Solutions®

Patient Medical History

Primary Care Physician ______________________ *Office Phone* ______________ *Date of Last Exam* __________

1. Are you under medical treatment now? ❑ Yes ❑ No

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ❑ Yes ❑ No

3. Are you taking any medication(s) including non-prescription medicine? ❑ Yes ❑ No

If yes, what medication(s) are you taking? ______________________

4. Have you ever taken Phen-Fen/Redux? ❑ Yes ❑ No

5. Do you use tobacco? ❑ Yes ❑ No

6. Do you use controlled substances? ❑ Yes ❑ No

7. Are you wearing contact lenses? ❑ Yes ❑ No

9. Are you allergic to or have you had any reactions to the following?

- Local anesthetics (e.g. Novocain) ❑ Yes ❑ No
- Penicillin or other antibiotics ❑ Yes ❑ No
- Sulfa drugs ❑ Yes ❑ No
- Barbiturates ❑ Yes ❑ No
- Sedatives ❑ Yes ❑ No
- Iodine ❑ Yes ❑ No
- Aspirin ❑ Yes ❑ No
- Any metals (e.g. nickel, mercury, etc.) ❑ Yes ❑ No
- Latex rubber ❑ Yes ❑ No
- Other (please list) ______________________

10. Women Only:

a.) Are you pregnant or think you might be pregnant? ❑ Yes ❑ No

b.) Are you nursing? ❑ Yes ❑ No

c.) Are you taking oral contraceptives? ❑ Yes ❑ No

8. Do you have or have you had any of the following?

High blood pressure ❑ Yes ❑ No	Heart disease ❑ Yes ❑ No	Chest pains ❑ Yes ❑ No
Heart attack ❑ Yes ❑ No	Cardiac pacemaker ❑ Yes ❑ No	Easily winded ❑ Yes ❑ No
Rheumatic fever ❑ Yes ❑ No	Heart murmur ❑ Yes ❑ No	Stroke ❑ Yes ❑ No
Swollen ankles ❑ Yes ❑ No	Angina ❑ Yes ❑ No	Hay Fever/allergies ❑ Yes ❑ No
Fainting/seizures ❑ Yes ❑ No	Frequently tired ❑ Yes ❑ No	Tuberculosis ❑ Yes ❑ No
Asthma ❑ Yes ❑ No	Anemia ❑ Yes ❑ No	Radiation therapy ❑ Yes ❑ No
Low blood pressure ❑ Yes ❑ No	Emphysema ❑ Yes ❑ No	Glaucoma ❑ Yes ❑ No
Epilepsy/convulsions ❑ Yes ❑ No	Cancer ❑ Yes ❑ No	Recent weight loss ❑ Yes ❑ No
Leukemia ❑ Yes ❑ No	Arthritis ❑ Yes ❑ No	Liver disease ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No	Joint replacement or implant ❑ Yes ❑ No	Heart trouble ❑ Yes ❑ No
Kidney diseases ❑ Yes ❑ No	Hepatitis/Jaundice ❑ Yes ❑ No	Respiratory problems ❑ Yes ❑ No
AIDS or HIV infection ❑ Yes ❑ No	Sexually transmitted diseases ❑ Yes ❑ No	Mitral Valve Prolapse ❑ Yes ❑ No
Thyroid problems ❑ Yes ❑ No	Stomach troubles/ulcers ❑ Yes ❑ No	Other ______________

Patient Dental History

Previous Dentist and Location ______________________ *Date of Last Exam* __________

1. Do your gums bleed while brushing or flossing? ❑ Yes ❑ No

2. Are your teeth sensitive to hot or cold liquids/foods? ❑ Yes ❑ No

3. Are your teeth sensitive to sweet or sour liquids/foods? ❑ Yes ❑ No

4. Do you feel pain to any of your teeth? ❑ Yes ❑ No

5. Do you have any sores or lumps in or near your mouth? ❑ Yes ❑ No

6. Have you had any head, neck, or jaw injuries? ❑ Yes ❑ No

7. Have you ever experienced any of the following problems in your jaw?

a.) Clicking? ❑ Yes ❑ No

b.) Pain (joint, ear, side of face)? ❑ Yes ❑ No

c.) Difficulty in opening or closing? ❑ Yes ❑ No

d.) Difficulty in chewing? ❑ Yes ❑ No

8. Do you have frequent headaches? ❑ Yes ❑ No

9. Do you clench or grind your teeth? ❑ Yes ❑ No

10. Do you bite your lips or cheeks frequently? ❑ Yes ❑ No

11. Have you ever had any difficult extractions in the past? ❑ Yes ❑ No

12. Have you ever had any prolonged bleeding following extractions? ❑ Yes ❑ No

13. Have you had any orthodontic treatment? ❑ Yes ❑ No

14. Do you wear dentures or partials? ❑ Yes ❑ No

If yes, date of placement ______________________

15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ❑ Yes ❑ No

16. Do you like your smile? ❑ Yes ❑ No

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.

I have read and agree with Dental Arts' HIPAA (Notice of Privacy Practices) statement.

Signature of Patient (or Parent if Minor) ______________________ Date __________

Doctor's Comments ______________________

____

______________________ Signature ______________________ Date ______________________