OZARK COMPREHENSIVE DENTISTRY

Patient Information Record

To ensure the best possible care, please review and complete the following questionnaire

NAME:	**DATE OF BIRTH (mm/dd/yr)**
SS #:	**PLEASE CIRCLE** **Minor Single Married Widowed Divorced Separated**
STREET ADDRESS:	**CITY:** **ZIP:**
HOME PHONE #:	**CELL PHONE #::**
EMAIL ADDRESS:	**WORK PHONE #:**
Name of Responsible Party	**EMPLOYER:**

Emergency Contact Information:

Name:_____ Phone #:_____

Whom may we thank for referring you?_____

Is another member of your family a patient at our office? YES NO

If yes, please list family members:_____

How long has it been since your last dental exam, cleaning and x-rays?_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	YES		YES
HEART - ARTIFICIAL HEART VALVE		ANEMIA	
- HISTORY OF ENDOCARDITIS		AIDS OR HIV INFECTION	
HIGH BLOOD PRESSURE		SEXUALLY TRANSMITTED DISEASE	
LOW BLOOD PRESSURE		HEPATITIS A B C D E	
RHEUMATIC FEVER		ARTHRITIS	
CANCER		EMPHYSEMA	
LEUKEMIA		STOMACK TROUBLES/ULCERS	
RADIATION THERAPY		JOINT REPLACEMENT/IMPLANT	
DIABETES		STROKE	
KIDNEY PROBLEMS		TUBERCULOSIS	
LIVER PROBLEMS		ASTHEMA OR RESPIRATORY PROBLEMS	
FAINTING SPELLS		GLAUCOMA	
EPILEPSY		THYROID PROBLEMS	
SEIZURES		SINUS PROBLEMS	
EXCESSIVE BLEEDING OR BRUISING		CIRULATORY PROBLEMS	

If an explanation is required for any of the above, please do so below:

_____

Have you been hospitalized for any serious illness or surgical operation within the last 5 years?

If so explain:_____

Are you currently taking any medication? If so please list:_____

Do you currently use or have you used tobacco? YES NO

WOMEN ONLY: Are you pregnant? YES NO

Are you trying to become pregnant? YES NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING? (Please check if applicable):

OZARK COMPREHENSIVE DENTISTRY

Patient Information Record

	YES		YES
LOCAL ANESTHESIA (e.g. Novocain)		IODINE	
PENICILLIN		ASPIRIN OR OTHER PAIN RELIEVERS	
SULFA DRUGS		METALS	
BARBITURATES		LATEX RUBBER PRODUCTS	
SEDATIVE		CODIENE	

ANY OTHER ALLERGIES:_____

HAVE YOU HAD ANY OF THE FOLLOWING?

	YES		YES
DO YOU HAVE ANY TOOTH ACHE?		ARE YOU A LOUD SNORER?	
ARE YOUR TEETH SENSITIVE TO HOT/COLD?		DO YOU WAKE UP GASPING FOR BREATH?	
ARE YOUR TEETH SENSITIVE TO SWEET/SOUR?		DO YOU FEEL SLEEPY DURING THE DAY?	
DO YOU CLENCH OR GRIND YOUR TEETH?		DO YOU WAKE UP OFTEN AT NIGHT?	
DOES YOUR JAW CLICK/POP OR HURT?		BEEN DIAGNOSED WITH SLEEP APNEA?	
DO YOU WEAR A NIGHT GUARD?		DO YOU USE A CPAP FOR SLEEP APNEA?	
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?		DO YOU LOVE YOUR CPAP?	
DO YOU HAVE FREQUENT HEAD ACHES/MIGRAINES?		DO YOU WEAR DENTURES OR PARTIALS?	
HAVE YOU EVER HAD GUM DISEASE?		ANY SORES/LUMPS IN OR NEAR YOUR MOUTH?	
DO YOUR GUMS BLEED WHEN BRUSHING/FLOSSING?		DO YOU THINK YOU HAVE BAD BREATH?	
DO YOU GET FOOD PACKED BETWEEN YOUR TEETH?		DO YOU BITE YOUR LIPS OR CHEEKS OFTEN?	

CONSENT TO TREATMENT: Please initial all statements

- **I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make thorough diagnoses regardless if insurance covers them or not. _____**
- **If you have current x-rays or tests performed by another doctor that you van email or bring with you, then we may not have to retake those. _____**
- **Upon such diagnosis, I authorize the doctor top perform all recommended treatment mutually agreed upon me and to employ such assistance as required to provide proper care. _____**
- **I agree to the used of anesthetics, sedatives and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. _____**
- **I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. *I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICES RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE BEFORE HAND*. _____**
- **I give permission to have messages left at home or work regarding my dental needs. _____**

PATIENT (or Responsible Party) SIGNATURE: **DATE:**

_____ _____