PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Blum Dental Clinic
700 24th Avenue S.W.
Norman, Oklahoma 73069
405-360-5566 Fax 405 360.3224
e-mail: blumdds@gmail.com

IF THIS APPOINTMENT IS FOR YOU START HERE

1			
DATE			
NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		CELL NO.	
EMAIL			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		CELL NO.	
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS IS NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO.

DENTAL INSURANCE 2	
PRIMARY CARRIER	
INSURANCE COMPANY	
EMPLOYEE	
DATE OF BIRTH	
GROUP NO.	
UNION OR LOCAL NO.	
DATE EMPLOYED	
EMP. SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
EMPLOYEE	
DATE OF BIRTH	
GROUP NO.	
UNION OR LOCAL NO.	
DATE EMPLOYED	
EMP. SOCIAL SECURITY NO.	

GETTING TO KNOW YOU 3		
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
THEIR NAME		
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

ACCOUNT INFORMATION 4	
YOU:	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE	EXT.
YOUR SPOUSE:	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE	EXT.

DENTAL HISTORY

Blum Dental Clinic
700 24th Avenue S.W.
Norman, Oklahoma 73069

Welcome to our office.

So we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is entirely confidential.

Reason for seeing the Doctor today _____

Date of last dental visit _____ **Last dental cleaning** _____ **Last full mouth x-rays** _____

What was done at your last dental visit? _____

Your previous Dentist's name _____ **Address** _____

City _____ **State** _____ **Zip** _____ **Phone** _____

How often do you see a dentist? _____ **How often do you brush?** _____ **How often do you floss?** _____

Do you use dental aids? (Toothpick, interplak, etc.) _____

Do you have dental problems now? Yes ☐ No ☐ If yes, describe _____

Are any of your teeth sensitive to:

Hot or Cold?	Yes ☐	No ☐
Sweets?	Yes ☐	No ☐
Biting or chewing?	Yes ☐	No ☐
Have you noticed any mouth odors or bad tastes?	Yes ☐	No ☐
Do you frequently get cold sores, blisters or any other oral lesions?	Yes ☐	No ☐
Do your gums hurt or bleed?	Yes ☐	No ☐
Have your parents experienced gum disease or tooth loss?	Yes ☐	No ☐
Have you noticed any loose teeth or change in your bite?	Yes ☐	No ☐
Does food become caught between your teeth?	Yes ☐	No ☐

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes ☐	No ☐
Bite your lips or cheeks regularly?	Yes ☐	No ☐
Hold object with your teeth? (Pencils, pins, nails, etc.)	Yes ☐	No ☐
Mouth Breathe while asleep or awake?	Yes ☐	No ☐
Have tired jaws, especially in the morning?	Yes ☐	No ☐
Smoke/chew tobacco?	Yes ☐	No ☐
Snore or gasp for air while sleeping?	Yes ☐	No ☐

Have you ever had:

Orthodontic treatment?	Yes ☐	No ☐
Oral surgery?	Yes ☐	No ☐
Periodontal treatment?	Yes ☐	No ☐
Your teeth ground or bite adjusted?	Yes ☐	No ☐
A bite plate or mouth guard?	Yes ☐	No ☐
A serious injury to the head or mouth?	Yes ☐	No ☐

If yes, describe, including the cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes ☐	No ☐
Pain? (Joint, ear, side of face)	Yes ☐	No ☐
Difficulty opening/closing the mouth?	Yes ☐	No ☐
Difficulty chewing on either side of your mouth?	Yes ☐	No ☐
Head, neck or shoulder aches?	Yes ☐	No ☐
Are you satisfied with the way your teeth look?	Yes ☐	No ☐
Would you like to keep all of your teeth all of your life?	Yes ☐	No ☐
Do you feel nervous about having dental treatment?	Yes ☐	No ☐

If yes, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience?	Yes ☐	No ☐

If yes, describe _____

_____

Is there anything else about having dental treatment you would like us to know? _____

_____

– PLEASE COMPLETE OTHER SIDE –

Patient Name **Account No.**

(Rev 01/13)

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? Yes ☐ No ☐

If yes, for what reason? _____

Physician's name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Have you taken any medication or drugs during the past two years? Yes ☐ No ☐

Are you currently taking any medication, drugs or pills? Yes ☐ No ☐

If yes, list name dosage _____

Are you aware of having an allergic or adverse reaction to any medication or substance? Yes ☐ No ☐

If yes, describe _____

Have you been a patient in the hospital during the past five years? Yes ☐ No ☐

Please indicate which of the following you have had, or have at present. Circle Y for Yes, N for No.

Heart Attack, Surgery or Disease...	Y	N	Ulcers	Y	N	Hepatitis A (infectious) B (serum) .	Y	N
Chest Pain	Y	N	Diabetes	Y	N	Venereal Disease	Y	N
Congenital Heart Disease	Y	N	Thyroid Problems	Y	N	A.I.D.S.	Y	N
Heart Murmur	Y	N	Glaucoma	Y	N	H.I.V. Positive	Y	N
High Blood Pressure	Y	N	Contact Lenses	Y	N	Cold Sores/Fever Blisters	Y	N
Mitral Valve Prolapse	Y	N	Emphysema	Y	N	Blood Transfusion	Y	N
Artificial Heart Valve	Y	N	Chronic Cough	Y	N	Hemophilia	Y	N
Heart Pacemaker	Y	N	Tuberculosis	Y	N	Sickle Cell Disease	Y	N
Rheumatic Fever	Y	N	Asthma	Y	N	Bruise Easily	Y	N
Arthritis/Rheumatism	Y	N	Hay Fever	Y	N	Liver Disease	Y	N
Cortisone Medicine	Y	N	Latex Sensitivity	Y	N	Yellow Jaundicé	Y	N
Swollen Ankles	Y	N	Allergies or Hives	Y	N	Neurological Disorders	Y	N
Stroke	Y	N	Sinus Trouble	Y	N	Epilepsy or Seizures	Y	N
Diet (Special/Restricted)	Y	N	Radiation Therapy	Y	N	Fainting or Dizzy Spells	Y	N
Artificial Joints (Hip, Knee, etc.)	Y	N	Chemotherapy	Y	N	Nervous/Anxious	Y	N
Kidney Trouble	Y	N	Tumors	Y	N	Psychiatric/Psychological Care	Y	N

Do you use more than two pillows to sleep? Yes ☐ No ☐

Have you lost or gained more than 10 pounds in the past year? Yes ☐ No ☐

Do you have or have you had any disease, condition, or problem not listed above? Yes ☐ No ☐

If yes, describe _____

Women: Are you pregnant? Yes ☐ - Months _____ No ☐ Nursing? Yes ☐ No ☐ Taking birth control pills? Yes ☐ No ☐

I understand the information on both sides of this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Doctor of any change in my health or medication. The undersigned hereby authorizes Doctor to take x-ray, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the patient. I further authorize and consent that Doctor choose and employ such assistance as deemed fit.

Patient Signature _____ Date _____

Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account. I, understand treatment plans are an estimate of insurance benefits. I, also understand that the responsibility of Children of Divorce are the parents.

Patient _____ Date _____ Witness _____