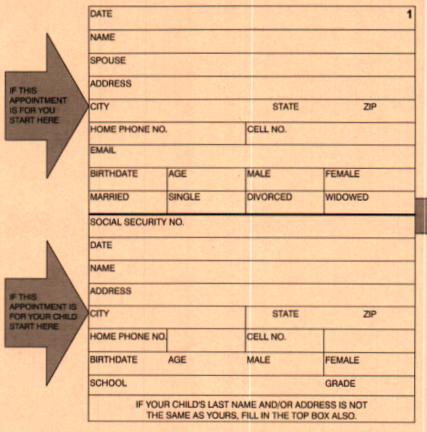
PATIENT REGISTRATION AND HEALTH HISTORY

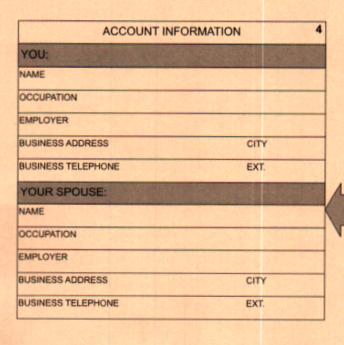
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION





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

	DENTAL INSURANCE
	PRIMARY CARRIER
INSURANCE	COMPANY
EMPLOYEE	BY COMMENT
DATE OF BIR	тн
GROUP NO.	
UNION OR LO	OCAL NO.
DATE EMPLO	YED
EMP. SOCIAL	SECURITY NO.
-	
	SECONDARY CARRIER
INSURANCE	Regulated States and Section 1995
INSURANCE EMPLOYEE	Regulated States and Section 1995
	COMPANY
EMPLOYEE	COMPANY
EMPLOYEE DATE OF BIR	COMPANY
EMPLOYEE DATE OF BIR GROUP NO.	TH XCAL NO.
DATE OF BIR GROUP NO. UNION OR LO	TH XCAL NO.
DATE OF BIR GROUP NO. UNION OR LO	TH DCAL NO. YED

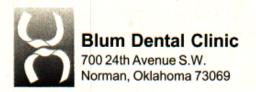


	GETTING TO	KNOW YOU		3
IS ANOTHER MEMB AT OUR OFFICE? THEIR NAME	ER OF YOUR FAMILY	OR RELATIVE	A PATIENT	
REFERRED TO US E	BY			
YOUR FORMER ADD	DRESS			
CITY		STATE	ZIP	
PERSON TO CONTA	CT FOR EMERGENC	Y		
PHONE NUMBER				
ADDRESS				
CITY		STATE	ZIP	
CLOSEST RELATIVE	NOT LIVING WITH Y	rou		
PHONE NUMBER				
ADDRESS				
CITY		STATE	ZIP	

DENTAL HISTORY

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.



Date of last dental visit				Last full mouth x-rays				
Your previous Dentist's name Address								
City	State		Zip	Phone				
How often do you see a dentist?		How ofte	n do you brush?	How often do y	ou floss	?		
Do you use dental aids? (Toothpic	k, interp	lak, etc.)_						
Do you have dental problems no	w? Yes	□ No □	If yes, describe_					
Are any of your teeth sensitive to:			1	Have you ever had:				
Hot or Cold?	Yes	No 🗖		Orthodontic treatment?	Yes 🗆	No 🗆		
Sweets?	Yes 🗆	No 🗆		Oral surgery?	Yes 🗆	No 🗆		
Biting or chewing?	Yes 🗆	No 🗆		Periodontal treatment?	Yes 🗆	No 🗆		
Have you noticed any mouth			Your teeth	ground or bite adjusted?	Yes	No 🗆		
odors or bad tastes?	Yes	No 🗆	A bite plate or mouth guard?		Yes 🗆	No 🗆		
Do you frequently get cold sores, blisters or any other oral lesions?	Yes 🗆	No 🗆	A serious injury to the head or mouth? If yes, describe, including the cause		Yes 🗆	No 🗖		
Do your gums hurt or bleed?	Yes 🗆	No 🗆						
Have your parents experienced gum disease or tooth loss?	Yes 🗆	No 🗆	Hav	ve you experienced:				
Have you noticed any loose teeth or	Clicking or nonning of the law?		Yes	No 🗆				
change in your bite?	Yes	No 🗆	Pain?	(Joint, ear, side of face)	Yes	No 🗆		
Does food become caught between your teeth?	Yes 🗆	No 🗆	Difficulty ope	ning/closing the mouth?	Yes 🗆	No 🗆		
yes, where?	163 🗖	No L	Diff	iculty chewing on either	_			
Do you:				side of your mouth?	Yes	No 🗆		
Clench or grind your teeth while	V			neck or shoulder aches?	Yes	No 🗆		
awake or asleep?	Yes 🗆	No 🗆	Are ye	ou satisfied with the way your teeth look?	Yes 🗆	No 🗆		
Bite your lips or cheeks regularly?	Yes 🗆	No 🗆	Would yo	u like to keep all of your	V	N		
Hold object with your teeth? (Pencils, pins, nails, etc.)	Yes	No 🗆	Da	teeth all of your life?	Yes 🗆	No 🗆		
Mouth Breathe while asleep or awake?	Yes 🗆	No 🗆	Do you te	dental treatment?	Yes 🗖	No 🗖		
Have tired jaws, especially in			If yes, what is you	r biggest concern?				
the morning?	Yes	No 🗖	Have ve	ou ever had an upsetting				
Smoke/chew tobacco?	Yes	No 🗆	nave yo	dental experience?	Yes 🗆	No 🗆		
Snore or gasp for air while sleeping?	Yes 🗆	No 🗆	If yes, describe	-				

- PLEASE COMPLETE OTHER SIDE -

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

MEDICAL HISTORY

Have you been under the care of a medical of	loctor 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 dur		Yes □ No □		
Are you currently taking any medication, dru	igs or pills? Yes Li No I	_		
If yes, list name dosage				
Are you aware of having an allergic or adver	se reaction to any medica	tion or substance?	Yes □ No □	
If yes, describe				
Have you been a patient in the hospital during	ng the past five years?	Yes ☐ No [.	
Please indicate which of the following you h	ave had, or have at presen	t. Circle Y for Yes,	N for No.	
Heart Attack, Surgery or Disease Y N	Ulcers			
Chest Pain Y N	Diabetes			
Congenital Heart Disease Y N	Thyroid Problems			
Heart Murmur Y N	Glaucoma	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
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 Jaundice	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		
Artificial Joints (Hip, Knee, etc.) Y N	Chemotherapy			
Kidney Trouble Y N	Tumors	Y N		
Do you use more than two pillows to slee	p? Yes □ No □			
Have you lost or gained more than 10 pour	inds in the past year? Y	es 🗆 No 🗆		
Do you have or have you had any disease	e, condition, or problem no	ot listed above? Ye	s No 🗆	
If yes, describe				<u> </u>
Women: Are you pregnant? Yes ☐ - Mont	hs No 🗆 Nursir	ng? Yes□ No□	Taking birth control pills? You	es 🗆 No 🗆
I understand the information on both sides of this form is knowledge. If further information is needed, you have my Doctor of any change in my health or medication. The und by Doctor to make a thorough diagnosis of the patient's do in connection with the patient. I further authorize and constitutions	permission to ask the respective hersigned hereby authorizes Doctor ental needs. I also authorize Docto	ealth care provider or age to take x-ray, study models r to perform any and all for	ncy, who may release such information to photographs, or any other diagnostic aids ms of treatment, medication and therapy,	you. I will notify the deemed appropriate
Patient Signature			Date	
Lastly, I understand that all responsibility for payment for unless other arrangements have been made. In the event p account. I, understand treatment plans are an estimate of i	ayments are not received by the ag	reed upon dates, I understa	and that a 1-1/2% finance charge (18% APR	services are rendered) may be added to my
Patient	Date	Witnes		
Patient	Date	AAIGIES	-	