PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Blum & Tinsley 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

IF THIS APPOINTMENT IS FOR YOUR CHILD 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.

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.

2

DENTAL INSURANCE

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.

3

GETTING TO KNOW YOU

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

4

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

DRIVERS LICENSE NO. | RELATIONSHIP TO PATIENT

BANK

BRANCH

ACCOUNT NO.

YOU:

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS TELEPHONE | EXT.

YOUR SPOUSE: (IF APPLICABLE)

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS TELEPHONE | EXT.

DENTAL HISTORY

Blum & Tinsley 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 D	No☐
Biting or chewing?	Yes D	No0
Have you noticed any mouth odors or bad tastes?	Yes ☐	No ☐
Do you frequently get cold sores, blisters or any other oral lesions?	Yes D	No 0
Do your gums hurt or bleed?	Yes D	No 0
Have your parents experienced gum disease or tooth loss?	Yes D	No0
Have you noticed any loose teeth or change In your bite?	Yes D	No ☐
Does food become caught between your teeth?	Yes D	No☐

If yes, where? _____

Do you:

Clench or grind your teeth while **awake** or asleep?	Yes D	No 0
Bite your lips or cheeks regularly?	Yes D	No 0
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 D	No ☐
Smoke/chew tobacco?	Yes☐	No0
Snore or gasp for air whlle sleeping, Wear a CPAP or been diagnosed with sleep Apnea?	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 D	No D
Pain? (Joint, ear, side of face)	Yes☐	No D
Difficulty opening/closing the mouth?	Yes ☐	No0
Difficulty chewing on either side of your mouth?	Yes☐	No☐
Head, neck or shoulder aches?	Yes☐	No☐
Are you satisfied with the wa your teeth look.	Yes ☐	No
Would you like to keep all of lour teeth all of your ife?	Yes ☐	No
Do you feel nervous about havln dental treatment	Yes ☐	No ☐

If yes, what Is your biggest concern? _____

Have you ever had an upsettln dental experience	Yes ☐	No ☐

If yes, describe _____

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 doctor during the past two years? Yes O 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 0 No☐

Are you currently taking any medications, drugs, pills including medical marijuana Yes No

If yes, list name dosage _____

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

Ifyes, 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**	Vepereal 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
Mitra! Valve Prolapse	Y	N	Emphysema	Y	**N**	Blood Transfusion	Y	N
Artificial Heart Valve	Y	N	Migraines	Y	N	HemophIlla	Y	N
Heart Pacemaker	Y	N	Autoimmune Disease.....	Y	**N**	Sickle Cell Disease	Y	N
Rheumatic Fever	Y	N	Asthma	Y	**N**	Bruise Easily	Y	N
Arthritis/Rheumatism	Y	N	Sleep Apnea.....	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**	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 D No ☐

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

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

If yes, describe _____

Women: Are you pregnant? Yes D - Months_____ No D Nursing? Yes D No D Taking birth control pills? Yes D No D

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 authorlz.es 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, medicaUon and therapy, that may be Indicated In connection with thepatient. 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 th• time services are rendered unle.ss other arrangements have been made. In the avant payments are not received by the agreed upon dates, I understand that a1·1/2o/e 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 responsibillty of Children of Divorce are the parents.

Patient _____ Date _____ Witness _____