Welcome To Pure Dental

Steven D. Oliver, DDS
6540 E 121st St., Bixby, OK 74008

PATIENT INFORMATION

Date _____

SSN _____

Patient _____

Address _____

City _____State_____Zip_____

Email _____

Sex M F Birthdate _____

Married Divorced Single Widowed Separated

Employer _____

Employer Address _____

Employer Phone _____

SPOUSE INFORMATION

Spouse _____

Spouse Birthdate _____

Spouse SSN _____

Spouse Employer _____

DENTAL INSURANCE

Who is responsible for this account? _____

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group # _____

Subscriber Name _____

Subscriber ID # _____

Subscriber Birthdate _____

Subscriber Employer _____

ASSIGNMENT AND RELEASE

I certify that I, and/or dependent(s), have insurance coverage with _____ (ins co) and assign directly to Dr. Steven Oliver all insurance benefits, if any, otherwise payable to me for services rendered. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. I understand that this office will prepare and file my insurance to assist in making collections from insurance companies and will credit such collections to my account. However, I understand that this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Signature of Patient, Parent/Guardian

_____

Date _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

Referred by a Friend Internet Website Sign by Building Direct Mailing Yellow Pages Newspaper Other

If you were referred, whom may we thank for referring you? _____

PHONE NUMBERS

Home _____ Work _____ Cell _____ Spouse _____

Best time and number to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____ Phone _____

HEALTH HISTORY

Have you ever had any of the following

Y N Anemia
Y N Artificial Valves
Y N Artificial Joints
Y N Asthma
Y N Back Problems
Y N Bleeding (abnormally)
Y N Cancer
Y N Chemotherapy
Y N Chemical Dependency
Y N Circulatory Problems
Y N Diabetes
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fever Blisters
Y N Glaucoma
Y N Heart Attack
Y N Heart Surgery
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Nervous Problems
Y N Psychiatric Care
Y N Scarlett Fever
Y N Stroke
Y N Radiation Treatment
Y N HIV/AIDS
Y N Tuberculosis
Y N Headaches
Y N Venereal Disease
Y N Ulcers

Are you pregnant or nursing? _____

I smoke or use tobacco _____

If yes, how much? _____ How many years _____

Physician Name _____

Physician Phone _____

DENTAL HISTORY

Reason for today's visit _____

Previous Dentist _____

Reason for changing dentist _____

Are you nervous about seeing the dentist? _____

If yes, why? _____

Do you require antibiotics before dental treatment? _____

How often do you brush _____ Floss _____

Y N I like my smile
Y N I clench/grind my teeth
Y N I want my smile whiter
Y N I want my teeth straighter
Y N My gums bleed when I brush or floss
Y N I have jaw problems related to TMJ
Y N I have had orthodontics
Y N I have problems eating
Y N My jaw pops and/or clicks
Y N My teeth are sensitive to cold
Y N My teeth are sensitive to heat
Y N My teeth are sensitive to sweets
Y N I have dry mouth
Y N I have bad breath

Date of last exam _____

Date of last dental xrays _____

MEDICATIONS

Please list all medications you are currently taking

Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____

Pharmacy _____Phone_____

ALLERGIES

Are you allergic to any of the following?

Aspirin
Ibuprofen
Sulfa Drugs
Penicillin
Codeine
Latex
Dental Anesthetics
Metals
Other _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient, Parent/Guardian _____ Date _____

UPDATES

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein.

Date_____ Comments_____ Signature _____
Date_____ Comments_____ Signature _____
Date_____ Comments_____ Signature _____