

**Ozarks Preferred Dental**

**Robert K. Reynolds, DDS**

PATIENT INFORMATION:

First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI\_\_\_\_\_\_\_\_Nickname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Driver’s License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€Male €Female / €Married €Single €Divorced €Widowed / Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Methods of Contact (for appointment reminders): €Mail € Phone €Email €Text

Who can we thank for referring you, or how did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact/Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYMENT AND INSURANCE:

Patient’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured/Responsible Party: €SELF €SPOUSE €PARENT €OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Patient is a Minor, Name of Responsible Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If other than self, Name of Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is authorized to receive information about your appointments/treatment/account?

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION: I authorize payment of my insurance directly to Dr. Robert Reynolds otherwise payable by me. I understand that I am responsible for all costs of dental treatment, regardless of insurance payment. I hereby authorize Dr. Robert Reynolds to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

I have had the full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that, by signing this form, I am giving consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Would you like to receive a copy of the NOTICES OF PRIVACY PRACTICES? € Yes €No

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Do you have, or have ever had, any of the following? (**Check all that apply**)

* Low Blood pressure
* Lung Disease
* Mitral Valve Prolapse
* Neurological Disorders
* Osteoporosis
* Psychiatric/Psychological Care
* Rheumatic Fever
* Spina Bifida
* Sinus Trouble
* Sleep Apnea
* Stomach Problems/Ulcers
* Stroke
* Swelling of Limbs
* Thyroid Problems
* Tonsillitis
* Tuberculosis
* Tumors/Growths
* Yellow Jaundice

* Congenital Heart Disease
* Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_
* Epilepsy/Seizures/Fainting
* Excessive Bleeding
* Excessive Thirst
* Frequent Headaches/Migraines
* Hemophilia
* Heart Attack
* Heart Murmur
* Heart Pace Maker
* Hepatitis ( A , B , C ) circle one
* Herpes
* High Blood Pressure
* Hypertrophic Cardiomyopathy
* Irregular Heartbeat
* Joint Replacement
* Kidney Problems/Disease
* Latex Sensitivity/Allergy
* Liver Disease
* AIDS/HIV
* Anemia
* Anaphylaxis
* Abnormal Bleeding
* Arthritis
* Artificial Joints
* Asthma/Emphysema
* Artificial Heart Valve
* Autoimmune Disease
* Blood Disease
* Blood Transfusion
* Breathing Problem/Disorder
* Bruise Easily
* Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Chemical Dependency
* Chemotherapy/Radiation
* Chest Pains
* Cold Sores/Fever Blisters

Have you ever had any serious illness not listed above? Y or N If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last medical exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under a Physician’s care now? Y or N Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list of current medications including prescriptions, OTC, Vitamins, and herbal remedies:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?**

€Aspirin €Penicillin €Codeine €Acrylic €Metal €Latex €Local Anesthetics €Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use Tobacco? Y or N Do you use controlled substances? Y or N

**WOMEN:** Pregnant? Y or N Nursing Y or N

**DENTAL HISTORY:**

Date of last dental visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason for today’s visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy with the overall appearance of your teeth?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Bleeding Gums € Pain when Chewing € Clenching/Grinding
* Broken Teeth/Fillings € Loose Teeth € Mouth Sores or Growths
* Decayed Teeth € Dental Pain € Sensitivity to Cold/Hot/Sweets
* Food Impaction € Periodontal Disease € Headaches
* Snoring € Choking or coughing during sleep

Do you have any other dental concern not listed above? Y or N Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_