



Ozark's Preferred Dental Group

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)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric/Psychological Care |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Hepatitis (A , B , C) circle one | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Angina/Chest Pains | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sjogren's Syndrome |
| <input type="checkbox"/> Artificial (Prosthetic) Joints | <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Infective Endocarditis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes Type 2: HbA1C _____ | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Stomach Problems/Ulcers |
| <input type="checkbox"/> Artificial (Prosthetic) Heart Valve | <input type="checkbox"/> Epilepsy/Seizures/Fainting | <input type="checkbox"/> Kidney Problems/Disease | <input type="checkbox"/> Stroke: Date _____ |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease/Jaundice | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Headaches/Migraines | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Erythematousus |
| <input type="checkbox"/> Breathing Problem/Disorder | <input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Oral or IV Bisphosphonates ex:
Zometa, Boniva, Reclast | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer: Type _____ | <input type="checkbox"/> Heart Attack: Date _____ | | <input type="checkbox"/> Tumors/Growths |

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? _____

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Food Impaction | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Choking or coughing during sleep | <input type="checkbox"/> Sensitivity to Cold/Hot/Sweets |
| <input type="checkbox"/> Broken Teeth/Fillings | <input type="checkbox"/> Snoring | <input type="checkbox"/> Dental Pain | <input type="checkbox"/> Clenching/Grinding | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Decayed Teeth | <input type="checkbox"/> Pain when Chewing | <input type="checkbox"/> Periodontal Disease | <input type="checkbox"/> Mouth Sores or Growths | |

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

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction, I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE _____ **DATE** _____