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**)

- ☐ 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
- ☐ 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
- ☐ 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

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

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