OAK TREE DENTISTRY
YOUR SMILES. OUR PASSION.

Patient Registration

First Name:_____Last Name:_____Middle Initial: _____

Preferred Name: _____

Responsible Party (If someone OTHER than patient, please fill out below):

First Name:_____Last Name:_____Middle Initial: _____

Address:_____Mailing (if different): _____

City, State, Zip Code:_____

Home Phone:_____Cell Phone:_____Work Phone: _____

Birth Date:_____Age:_____Social Security#:_____Drivers License: _____

Patient Information:

Address:_____Mailing (if different): _____

City, State, Zip Code: _____

Home Phone:_____Cell Phone:_____Work Phone: _____

Birth Date:_____Age:_____Social Security#:_____Drivers License: _____

Email:_____ *Would you like to receive correspondences via e-mail?* Y or N

Sex: ⊣ Male or ⊣ Female Marital Status: ⊣ Single ⊣ Married ⊣ Divorced ⊣ Separated ⊣ Widowed

Employment Status: ⊣ Full Time ⊣ Part Time ⊣ Retired ⊣ Unemployed **Emergency Contact:** _____

Student Status: ⊣ Full Time ⊣Part Time ⊣ Neither **Phone#:** _____

Primary Insurance Information:

Name of insured:_____Relationship to Pt:_____Social Security#:_____Birth Date:_____

Employer:_____ Insurance Company: _____

Address:_____ Address: _____

City, State, Zip:_____ City, State, Zip: _____

Secondary Insurance Information:

Name of insured:_____Relationship to Pt:_____Social Security#:_____Birth Date: _____

Employer:_____ Insurance Company: _____

Address:_____ Address: _____

City, State, Zip:_____ City, State, Zip: _____

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Medical History

Are you under a physicians Care? .....Y N
Who is your Primary Care Doctor?_____
Have you ever been hospitalized or had a major operation?...Y N
Are you taking any medications, pills, or drugs?.....Y N
Do you take, or have you taken Phen-fen or Redux?..... Y N

Are you on a special Diet?..Y N
Do you use tobacco?..... Y N
Have you ever taken Fosamax, Boniva, Actonel, or any other medications that contain biphosphonates?... Y N

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

_____
_____
_____
_____

Are you allergic to any of the following? (Please CIRCLE if yes)

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal

Latex Sulfa Drugs OTHER: _____

***Women**:*

Are you pregnant/ trying to get pregnant? Y N *Taking Oral Contraceptives? Y N* *Nursing? Y N*

Do you have, or have you had, any of the following? (√ those that apply)

____ AIDS/HIV
____Alzheimer's Disease
____Anaphylaxis
____Anemia
____Angina
____Arthritis/Gout
____Artificial Heart Valve
____Artificial Joint
____Asthma
____Blood Disease
____Blood Transfusion
____Breathing Problem
____Bruise Easily
____Cancer
____Chemotherapy
____Chest Pains
____Cold Sores
____Convulsions
____Cortisone Medicine
____Diabetes
____Drug Addiction
____Easily Winded
____Emphysema
____Epilepsy/seizures
____Excessive Bleeding
____Excessive Thirst
____Fainting/Dizziness
____Frequent Cough
____Frequent Diarrhea
____Frequent Headaches
____Genital Herpes
____Glaucoma
____Hay Fever
____Heart Attack/Failure
____Heart Murmur
____Heart Trouble/Disease
____Hemophilia
____Hepatitis A
____Hepatitis B or C
____Herpes
____High Blood Pressure
____High Cholesterol
____Hives/Rash
____Hypoglycemia
____Irregular Heartbeat
____Kidney Problems
____Leukemia
____Liver Disease
____Low Blood Pressure
____Lung Disease
____Mitral Valve Prolapse
____Osteoporosis
____Pain in Jaw Joints
____Parathyroid Disease
____Radiation Treatments
____Recent Weight Loss
____Renal Disease
____Rheumatic Fever
____Rheumatism
____Scarlet Fever
____Shingles
____Sickle Cell Disease
____Sinus Trouble
____Spina Bifida
____Stomach Disease
____Stroke
____Swelling of Limbs
____Thyroid Disease
____Tonsilitis
____Tumors/Growths
____Ulcers
____Venereal Disease

Do you have any other serious illness NOT listed above? Y N _____

Comments/Questions? Is there anything NOT listed on this form you feel we need to know?

_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, OR Guardian_____Date _____