Dental Oasis
Family Dentistry

925-846-4491 925-846-1422
office@dentaloasispleasanton.com

PATIENT FORM

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance

Subscriber Name _____ Subscriber ID _____

Date of Birth _____ Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer Name _____

Employer Phone _____ Insurance Company _____

Insurance Group _____ Insurance Phone _____

Secondary Insurance

Subscriber Name _____ Subscriber ID _____

Date of Birth _____ Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer Name _____

Employer Phone _____ Insurance Company _____

Insurance Group _____ Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY *(If minor)*

Last Name: _____ First: _____ Initial: _____

Address *(If different)* _____ Date of Birth _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

EMERGENCY CONTACT

Last Name: _____ First: _____ Initial: _____

Telephone (☐ Mobile ☐ Work ☐ Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

(Responsible Party, if under 18)

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DENTAL & MEDICAL HEALTH HISTORY

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No		Yes	No
Bad breath	☐	☐	Head, neck, jaw pain, or aches	☐	☐
Blisters on lips or mouth	☐	☐	Lip or cheek biting	☐	☐
Burning sensation on tongue	☐	☐	Loose teeth or broken fillings	☐	☐
Chew on one side of mouth	☐	☐	Mouth breathing	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Orthodontic treatment	☐	☐
Smokeless tobacco	☐	☐	Nitrous Oxide	☐	☐
Dry mouth	☐	☐	Periodontal treatment	☐	☐
Food collection between teeth	☐	☐	Sensitivity to pressure or irritants	☐	☐
Clench or grind teeth	☐	☐	(cold, heat, sweets)		
Growths or sore spots in your mouth	☐	☐	How often do you floss? _____		
Gums swollen, tender or bleeding	☐	☐	How often do you brush? _____		

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ☐ Yes ☐ No

If Yes, please explain _____

Have you ever had trouble from previous dental care? ☐ Yes ☐ No

If Yes, please explain _____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____ Blood Pressure _____

Have you had any serious illnesses or operations ☐ Yes ☐ No

If yes, please describe _____

Have you ever had a blood transfusion ☐ Yes ☐ No If yes, give approximate dates _____

MEDICAL HISTORY

(Women) Are you pregnant? ☐ Yes ☐ No Due date _____ Nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Please check if you have/had:	Yes	No
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Required Hospitalization	☐	☐
Have you used steroids	☐	☐
Date of last episode ____	☐	☐
Bleeding abnormally with operations or surgery	☐	☐
Blood disease, clotting disorders	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type _____	☐	☐

	Yes	No
Herpes	☐	☐
High blood pressure	☐	☐
Any immune deficiency	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Pacemaker	☐	☐
Radiation treatments	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Sickle cell anemia	☐	☐
Skin rash	☐	☐
Slow healing wounds	☐	☐
Stroke	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tonsilitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐

MEDICAL HISTORY

Please check if you have/had:	Yes	No
Weight loss, unexplained	☐	☐
Do you wear contact lenses?	☐	☐
Do you consume alcoholic beverages?	☐	☐
Are you currently under the care of a Physician?	☐	☐
Are you allergic/sensitive to Latex?	☐	☐
Allergic to Penicillin, Aspirin, or other drugs?	☐	☐

If Yes, please specify _____

List any medications that you are taking: _____

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Reviewed by: _____ Date _____