OPPENHEIMER DENTISTRY

Today's Date: ______/______/______

Registration

Last name____________________ First Name_________________________

If Patient is under 18, Parent/Legal Guardian Last Name________________ First Name________________

Cell phone #_______________________ Work phone #_______________________

Address ____ Apt # _______________

City: _____________________________ State: ______________ Zip Code: ____________

Patient Date of Birth: ______/_______/________ Sex: Female/Male Single/Married

Soc. Sec. #______________________ Email: _________________________@_____________________

In case of emergency call: Name __________________________ phone #: __________________________

Relationship to patient: Parent/Guardian/Friend/Other_______________

How did you hear about our office: ______________________________

Insurance Info:

Do you have insurance? Yes/No Employer: _______________________________________

Name of Primary Insurance Company: _______________________ phone#:__________________________

Policy #: ____________________ Group #: _____________ Subscriber Social Security # ________________

Subscriber Name: _____________________________ Subscriber: D.O.B. ________/_______/________

Claim Address: ____

Do you have secondary insurance? Yes/No

Name of Secondary Insurance Company: _______________________ phone # _______________________

Policy #: ____________________ Group #: _____________ Subscriber Social Security # ________________

Subscriber Name: _____________________________ Subscriber D.O.B. ________/_______/________

Claim Address: ____

DENTAL HISTORY

Former Dentist: ___________________________ Phone #: ________________________

Address: _________________________________ City _________________ State ___________ Zip _________

Date of last dental visit: _____/_____/______ Date of last dental x-ray ______/_____/______

How often do you brush? _________________ How often do you floss? ___________________

Physician Name: _____________________ Phone #: ________________ Date of last visit: ___/____/____

Please circle any of the conditions that apply to you:

Bad Breath	Food collection between teeth	Orthodontic treatment
Bleeding gums	Pain around ear	Periodontal Treatment
Blisters on lips or mouth	Grinding teeth	Sensitivity to hot/cold
Burning sensation on tongue	Gums swollen or tender	Sensitivity to sweets
Chew on one side of mouth	Jaw pain or tiredness	Sensitivity when biting
Cigarette, Pipe/cigar smoking	Lip/cheek biting	Sores/growths in mouth
Clicking or popping of jaw	Loose teeth or broken fillings	Fingernail biting
Dry Mouth	Mouth Breathing	Mouth pain when brushing

Reason for today's visit: ____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of the drug Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)? Please circle: Yes or No

Please circle if you have had any of the following:

AIDS/HIV	Epilepsy	Radiation Treatment
Anemia, Rheumatism	Fainting or Dizziness	Respiratory Disease
Artificial Heart Valves	Glaucoma	Rheumatic Fever
Artificial Joints	Headaches	Scarlet Fever
Asthma	Heart Murmur	Shortness of Breath
Back Problems	Heart Problems	Sinus Problems

Bleeding abnormally, with Extractions or surgery	Hepatitis Type ____ Herpes	Skin Rash Special Diet
Blood Disease	High Blood Pressure	Stroke
Cancer	Jaundice	Swollen Feet/Ankles
Chemical Dependency	Jaw Pain	Swollen Neck Glands
Chemotherapy	Kidney Disease	Thyroid Problems
Circulatory Problems	Liver Disease	Tonsillitis
Congenital Heart Lesions	Low Blood Pressure	Tuberculosis
Cortisone Treatments	Mitral Valve Prolapse	Tumor or growth on head or neck
Cough, persistent or bloody	Nervous Problems	Ulcer
Diabetes	Pacemaker	Venereal Disease
Emphysema	Psychiatric Care	Weight Loss, Unexplained

Have you been told to premedicate before dental treatment? Yes or No

Are you pregnant? Yes or No Due Date: _______________ Are you nursing? Yes or No

Are you taking Birth Control Pills? Yes or No

Medications: List any medications you are currently taking and the correlated diagnosis

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ALLERGIES:

Please circle if you have any of the following:

Aspirin	Barbituates (Sleeping Pills)	Codeine	Iodine	Latex
Penicillin	Sulfa	Local Anesthetic (EPI)	Other: _____________________________	
Amoxicillin	Clindamycin			

Patient's Signature: __________________________ Date: _____/_____/_______

(Parent/Legal Guardian must sign if patient is under 18)

Doctor's Signature/Staff Signature: _________________________ Date: _____/_____/______