

## **Personal Information**

Name \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email Address \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Work # \_\_\_\_\_ Message # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Special Financial Information**

Please answer the following questions if the person responsible for your payment of your treatment is someone other than yourself.

Primary Insurance carrier:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Secondary Insurance Carrier:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature of the person responsible for this account:

\_\_\_\_\_ Date \_\_\_\_\_

# **Health History**

Physician's Name \_\_\_\_\_ Phone# \_\_\_\_\_

Please list all medications and dosages, including regular dosages of aspirin, and Vitamins and minerals that you are currently taking: \_\_\_\_\_

Have you ever had an allergic reaction to any medication or substance?

Y\_\_\_\_N\_\_\_\_If so please list:

Have you been under the care of a medical doctor during the past two years?

Y\_\_\_\_N\_\_\_\_If so, why? \_\_\_\_\_

Have you seen an ENT (Ear, Nose and Throat Doctor)? Y\_\_\_\_N\_\_\_\_

When? \_\_\_\_\_Why? \_\_\_\_\_

Dr's Name \_\_\_\_\_

Have you seen a chiropractor? Y\_\_\_\_N\_\_\_\_

When? \_\_\_\_\_Why? \_\_\_\_\_

Dr's Name \_\_\_\_\_

Have you seen a neurologist? Y\_\_\_\_N\_\_\_\_

When? \_\_\_\_\_Why? \_\_\_\_\_

Dr's Name \_\_\_\_\_

Is there other medical or treatment information that you would like to share with us? \_\_\_\_\_

It is vitally important that we understand your current health status. Please consider each of the concerns listed below very carefully before you answer. Indicate which of the following you have had, or have at present. Circle those that apply:

- |                        |                        |                     |
|------------------------|------------------------|---------------------|
| AIDS/HIV               | Excessive Bleeding     | Psychiatric care    |
| Anemia                 | Glaucoma               | Radiation           |
| Artificial Heart Valve | Hay Fever/ Sinus       | Respiratory Problem |
| Arthritis              | Heart Disease          | Rheumatic Fever     |
| Artificial Joints      | Heart Murmur           | Rheumatism          |
| Asthma                 | Hepatitis-A__ B_ C__   | Sickle Cell Disease |
| Blood Disease          | High Blood Pressure    | Stroke              |
| Cancer                 | Jaundice               | Stomach Problems    |
| Chemotherapy           | Kidney Trouble         | Thyroid Disease     |
| Cold/ Canker Sores     | Liver Disease          | Tobacco Use         |
| Diabetes -             | Mitral Valve Prolapse  | Tuberculosis        |
| Type 1__ Type 2 __     | Nervous Disorders      | Tumors              |
| Dizziness/ Fainting    | Neurological Disorders | Ulcers              |
| Epilepsy/ Seizures     | Pacemaker              | Venereal Disease    |

Allergies (please circle): Codeine, Aspirin, Penicillin, Latex, Erythromycin,  
Or Anesthetic (IE: Novocain, Lidocaine, etc.)

Please List Others: \_\_\_\_\_

Women, are you:

Pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_ Taking birth control pills? \_\_\_\_\_

Do you have or have you had any disease, condition or problem not listed? \_\_\_\_\_

Have you ever been told by a physician that you should take an oral antibiotic prior to receiving dental treatment? \_\_\_\_\_

Do you have a history of drug or alcohol abuse? \_\_\_\_\_

Have you ever had any cosmetic procedure? Yes \_\_\_ No \_\_\_

Give details: \_\_\_\_\_

## **Dental History**

Are you having any dental problems now? Please describe \_\_\_\_\_

\_\_\_\_\_

Have you ever had any complications with dental treatment? If yes, please explain: \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ For what? \_\_\_\_\_

Date of your last COMPLETE EXAM? \_\_\_\_\_ Full Mouth X-rays? \_\_\_\_\_

How was your last dental experience? \_\_\_\_\_

Are you apprehensive about dentistry? \_\_\_\_\_

Why? \_\_\_\_\_

\_\_\_\_\_

Do you have any of the following symptoms? (Circle those that apply.)

Insomnia

Limited Opening

Headaches Head Injuries

Jaw Pain

Frequent Waking

Jaw Popping

Loud Snoring

Neck Ache

Tingling in arms or fingers

Posture Problems

Trigeminal Neuralgia

Ringling in Ears/ Congested Ears

Facial Pain

Difficulty Swallowing

I understand that in order for Dr. O'Leary to provide my dentistry to the best of his ability, it is necessary for him to have the information I have provided. I have honestly answered all questions to the best of my knowledge. Should further information be needed from any of the health care providers I have listed, Dr. O'Leary has my permission to request and receive it. I will notify Dr. O'Leary of any future changes in my health or medications. I authorize O'Leary Dental Office to take x-rays, photographs, study models, or any other diagnostic aid that will assist in the comprehensive diagnosis of my dental needs. Also, I authorize O'Leary Dental Office to perform and administer agreed treatment, medication and therapy that may be indicated. I understand that the use of anesthetic agent embodies a certain risk. I also understand that I am fully responsible for all charges that I incur at O'Leary Dental Office.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Thank you! We're looking forward to seeing you soon...

[www.olearydental.com](http://www.olearydental.com)  
608-758-2004