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
Anemia
Artificial Heart Valve
Arthritis
Artificial Joints
Asthma
Blood Disease
Cancer
Chemotherapy
Cold/ Canker Sores
Diabetes –
Type 1__ Type 2 __
Dizziness/ Fainting
Epilepsy/ Seizures
Excessive Bleeding
Glaucoma
Hay Fever/ Sinus
Heart Disease
Heart Murmur
Hepatitis-A__ B_ C__
High Blood Pressure
Jaundice
Kidney Trouble
Liver Disease
Mitral Valve Prolapse
Nervous Disorders
Neurological Disorders
Pacemaker
Psychiatric care
Radiation
Respiratory Problem
Rheumatic Fever
Rheumatism
Sickle Cell Disease
Stroke
Stomach Problems
Thyroid Disease
Tobacco Use
Tuberculosis
Tumors
Ulcers
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
Headaches Head Injuries
Frequent Waking
Loud Snoring
Tingling in arms or fingers
Trigeminal Neuralgia
Facial Pain
Limited Opening
Jaw Pain
Jaw Popping
Neck Ache
Posture Problems
Ringing in Ears/ Congested Ears
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
608-758-2004