

Whom may we thank for referring you to our office: _____

Your Name: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work): _____

(Cell) _____ (E-Mail): _____

Birth Date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Employer: _____

If college student, school name: _____

City _____ State _____ Estimated date of grad _____

Person Responsible For Account

Name: _____ Relationship: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work): _____

Insurance Information

Minor Child- May Need To Complete Both Blocks For Patient Information
Adults- Complete Primary Insured
Dual Coverage? Also Complete Secondary Insured

Primary Insured				Secondary Insured			
_____	_____	_____	_____	_____	_____	_____	_____
Last	First	MI		Last	First	MI	
_____	_____	_____	_____	_____	_____	_____	_____
Street	City	State	Zip	Street	City	State	Zip
_____	_____	_____	_____	_____	_____	_____	_____
Home #	Work #	Fax#	email	Home #	Work #	Fax#	email
_____	_____	_____	_____	_____	_____	_____	_____
Birthdate (Mo/Day/Year)		Relationship to Patient		Birthdate (Mo/Day/Year)		Relationship to Patient	
_____		_____		_____		_____	
Employer		Dental Ins Company		Employer		Dental Ins Company	
_____		_____		_____		_____	
SS#	Subscriber #	Group #		SS#	Subscriber #	Group #	
_____	_____	_____		_____	_____	_____	

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
 Do you have dental examinations on a routine basis? Last visit _____ Yes No
 Do you like your smile? If not, why? _____ Yes No
 Do you ever have clicking, popping or discomfort in the jaw joint?..... Yes No
 Do you Brux or Grind?..... Yes No
 Do you smoke or chew? Any sores or growths in your mouth? Describe _____ Yes No

Has any member of your family ever been treated in our office?
 Yes No

Person to contact in case of emergency

Name of previous dentist (optional): _____
 Date of last full mouth x-rays (16 small films or panoramic): _____
 May we request a copy of your dental records?..... Yes No

Outside of Immediate Family Household
 Name _____
 Address _____
 City/State/Zip _____
 Telephone # _____

Authorization Signature: _____

Royal Oak Dental

Dr. Thomas Gilbert

Medical Alerts

Physician's Name _____ Date of Last Visit _____

Address _____ Phone _____

Please Circle **Y** (yes) if you **HAVE** or **N** (no) if you **Have Not** been treated for the following conditions:

- | | |
|---|--|
| 1. Y N Heart Murmurs | 23. Y N HIV/AIDS |
| 2. Y N Rheumatic Fever / Rheumatic Heart Disease | 24. Y N Arthritis |
| 3. Y N Congenital Heart Disease | 25. Y N Stroke |
| 4. Y N Cardiovascular Stent When _____ | 26. Y N Epilepsy |
| 5. Y N Artificial Joint Replacement | 27. Y N Diabetes |
| 6. Y N Artificial Heart Valve | 28. Y N Hypo / Hyper Thyroidism |
| 7. Y N High Blood Pressure | 29. Y N Prolonged / Excessive Bleeding |
| 8. Y N Angina | 30. Y N Hemophilia |
| 9. Y N Heart Attack When _____ | 31. Y N Liver Disease |
| 10. Y N Arrhythmia What Type _____ | 32. Y N Anticoagulation Therapy – Blood Thinners |
| 11. Y N Congestive Heart Failure | 33. Y N Anemia |
| 12. Y N Emphysema | 34. Y N Sickle cell Anemia |
| 13. Y N Asthma | 35. Y N Cancer |
| 14. Y N Tuberculosis | 36. Y N Radiation Therapy |
| 15. Y N Kidney Disease | 37. Y N Chemotherapy |
| 16. Y N Hemodialysis | 38. Y N Behavioral / Psychiatric Disorders |
| 17. Y N Hepatitis | 39. Y N Latex Allergy |
| 18. Y N Cirrhosis | 40. Y N Are You Pregnant? |
| 19. Y N Alcohol Abuse | |
| 20. Y N Ulcers | |
| 21. Y N Have you ever been hospitalized for any of the above conditions: Describe _____ | |

Give details of positive findings _____

22. Y N Other conditions we should know about? Please List: _____

Medications:

Do you have any allergies? (drug, medicine, food) Y N

Over the Counter _____

Please list: _____

RX Medications _____

Herbal Supplements _____

Authorization

I hereby authorize payment directly to Royal Oak Dental. I understand I am responsible for all costs of dental treatment regardless of insurance or third party payors. I authorize Royal Oak Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information I have provided in the dental/medical histories is correct. I grant the right to the office of Royal Oak Dental to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
(Patient or responsible party)

Date _____ State Drivers License _____