Welcome

Corwin Family Dentistry
221 East 7th Avenue
Bristow, OK 74010
918-367-3290

Date_____

Responsible Party

Name Of Person Responsible For The Account_____ SS#_____

Address_____ City_____ State_____ Zip_____

Driver's License #_____ Birthday_____

Employer_____ Work Phone_____ Home Phone_____

Patient Information (CONFIDENTIAL)

Name_____ _____Birthdate_____Home Phone_____

Address _____City_____State_____Zip_____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed SSN#_____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency_____Phone_____

Insurance Information

Name of Insured_____Relationship to Patient_____

Birthdate_____Social Security #_____

Name of Employer _____Work Phone_____

Address of Employer_____City_____State_____Zip_____

Insurance Company_____Group # _____Policy/ID #_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____Relationship to Patient_____

Birthdate_____Social Security #_____

Name of Employer_____Work Phone_____

Address of Employer_____City_____State_____Zip_____

Insurance Company_____Group #_____Policy ID#_____

Over Please

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any reason within the last 5 years?	☐	☐
If yes, please explain_____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, _____		
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you wearing contact lenses?	☐	☐
7. ADHD/Pshycological Disorders	☐	☐

8. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)_____		
9. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Abnormal Bleeding	☐	☐	Emphysema	☐	☐	Heart Surgery	☐	☐	Rheumatic Fever	☐	☐
Allergies	☐	☐	Epilepsy	☐	☐	Heart Valve Replacement	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Fainting Spells	☐	☐	Hepatitis/Jaundice	☐	☐	Sexual Transmitted Disease	☐	☐
Angina Pectoris	☐	☐	Fever Blisters	☐	☐	High Blood Pressure	☐	☐	Shingles	☐	☐
Arthritis	☐	☐	Frequent Headaches	☐	☐	Joint Replacement	☐	☐	Sickle Cell Disease	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐	Kidney Problems	☐	☐	Sinus Problems	☐	☐
Blood Disorder	☐	☐	HIV - AIDS	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Blood Transfusion	☐	☐	Hay Fever	☐	☐	Low Blood Pressure	☐	☐	Substance Abuse	☐	☐
Cancer/Chemotherapy	☐	☐	Heart Attack	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Problems	☐	☐
Diabetes	☐	☐	Heart Disease	☐	☐	Pace Maker	☐	☐	Tuberculosis	☐	☐
Difficulty Breathing	☐	☐	Heart Murmur	☐	☐	Radiation Therapy	☐	☐	Ulcers	☐	☐

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do your have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever have any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement_____		
15. Is there anything you want to change about your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my or my child during the period of such Dental care to third party payors and/or health practitioners.

X_____

Signature of Patient (or parent if minor) Date