Welcome to Oakland City Dental

Dental Registration History

Dr. Dahab T. Gaime
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PATIENT INFORMATION

Patient Name_____

Date:_____ Birthday_____

SSN or Insurance ID_____

Address:_____

City:_____ State_____ Zip_____

Home Tel:_____ Work Tel:_____

Mobile#_____ Occupation:_____

Email:_____ Martial Status_____

Referral Source:_____

Notes:_____

Emergency Contact

Name:_____

Address:_____

City _____State _____Zip_____

Phone:_____

Relationship:_____

INSURANCE INFO

Responsible Party:_____

Relationship to Patient:_____

Insurance Company:_____

Subscribers Name:_____

Group#:_____ SSN#:_____

Birthday:___/___/__Do you have other Coverage? Yes

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with:_____

and assign directly to Dr._____
all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information in the above-named insurance Company(ies) and their agents for their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan to completed or one year from the date signed below.

Signature:_____ Date:_____

EMPLOYER / SCHOOL

Employer/School Name_____

Address:_____

City:_____ State_____ Zip _____

Phone:_____ Email:_____

Notes:_____

DENTAL HISTORY

Reason for today's Visit?_____

Former Dentist:_____ Tel:_____ Last X-Ray Date:_____

Last Cleaning Date:_____ Last Dental Visit:_____

Do you feel pain? Y/N_____ If Yes, please describe:_____

Do you feel numbness, swelling or any other sensitivity? Y/N _____If yes please explain:_____

_____

_____Additional

Comments about your past dental History?:_____

_____

CONFIDENTIAL HEALTH HISTORY

I. _____ CHOOSE APPROPRIATE ANSWERS? (Leave blank if you do not understand the question)_____

1. Select One Is your general health good?
   If NO, please explain:_____
2. Select One Has there been a change in your health within the last year?
   If YES, please explain:_____
3. Select One Have you gone to the hospital or emergency room or had a serious illness in the last three months?
   If YES, please explain:_____
4. Select One Are you being treated by a physician now? If Yes explain:_____
   Date of last medical exam?_____ Reason for visit:_____
5. Select One Have you had problems with prior dental treatments?
   If YES, please explain:_____
6. Select One Are you in pain now?
   If YES, please explain:_____

II._____ HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING ?(Please Choose Yes or No**)**_____

Yes	Chest Pain (Angina)	Yes	Blood in stool	Yes	Frequent vomiting
Yes	Fainting Spells	Yes	Diarrhea or constipation	Yes	Jaundice
Yes	Recent weight loss	Yes	Frequent urination	Yes	Dry Mouth
Yes	Fever	Yes	Difficulty urinating	Yes	Excessive
Yes	Night Sweats	Yes	Ringing in ears	Yes	Chest thirst
Yes	Persistent Cough	Yes	Headaches	Yes	Difficulty swallowing
Yes	Coughing blood	Yes	Dizziness	Yes	Swollen ankles
Yes	Bleeding Problems	Yes	Blurred vision	Yes	Joint pain or stiffness
Yes	Blood in urine	Yes	Bruise easily	Yes	Shortness of breath
				Yes	Sinus problems

III._____ HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Choose Yes or No**)**_____

Yes	Heart Disease	Yes	AIDS/HIV	Yes	Eating Disorders
Yes	Genetic Heart Problems	Yes	Surgeries	Yes	Psychiatric Care
Yes	Heart attack	Yes	Hospitalization	Yes	Osteoporosis
Yes	Artificial joint	Yes	Diabetes	Yes	Asthma
Yes	Stomach problems/ulcers	Yes	Genetic Diabetes	Yes	Hepatitis/ STDs
Yes	Heart Defects	Yes	Tumors / Cancer	Yes	Herpes
Yes	Heart murmur	Yes	Chemotherapy	Yes	Canker / Cold Sores
Yes	Rheumatic fever	Yes	Radiation	Yes	Anemia
Yes	Skin desease	Yes	Arthritis/ rheumatism	Yes	Liver Disease
Yes	Hardening of arteries	Yes	Emphysema/lung disease	Yes	Eye Disease
Yes	Cosmetic Surgery	Yes	Kidney/Bladder disease	Yes	Transplant
Yes	Seizures	Yes	Stroke	Yes	Tuberculosis

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VI._____ ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?_____

Yes	**Aspirin**	Yes	**Valium / Sedative**	Yes	**Codeine / Narcotics**
Yes	**Penicillin /Antibiotics**	Yes	**Latex**	Yes	**Food**
Yes	**Nitrous Oxide**	Yes	**Local Anesthetic**	Yes	**Metal**

V.____ ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST 3 MONTHS?____

Yes	**Coffee / Tea**	Yes	**Tobacco**	Yes	**Antibiotics**
Yes	**Recreational Drugs**	Yes	**Alcohol**	Yes	**Supplements**
Yes	**Over the counter medicine**	Yes	**Bisphosphonate**	Yes	**Aspirin**
Yes	**Weight Loss medicine**	Yes	**Anti- Depressants**	Yes	**Herbal Supplements**

VI.____WOMEN ONLY: (Please Choose Yes or No for each)_____

- Yes **Are you or could you be pregnant? If yes, what month?_____**
- Yes **Are you nursing?**
- Yes **Are you taking birth control pills?**

VI._____ ALL PATIENTS: (Please choose Yes or No for each)_____

Yes **Do you have or have you had any other diseases or medical problems NOT listed on this form?**

If yes, please explain_____

_____

Yes **Have you ever been pre-medicated for dental treatments? If YES, why?_____**

_____

Yes **Have you ever taken Fen-Phen? If YES, when:_____**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician

Patients Signature_____ Date:_____

Physicians Signature_____ Date:_____

Whom would you like us to contact in case of an emergency?

Name:_____ Relationship:_____ Phone:_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and or medication. Further, I will not hold my dentist, or any other member of her staff, responsible for any errors or omissions that may have been made in the completion of this form.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) Date Dr. Dahab T. Gaime Date

Medical Update

I have reviewed my HEALTH HISTORY and confirm that it accurately states past and present conditions

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DR. G
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____