# NEW PATIENT INFORMATION
# MINOR CHILD

2209 South Main Street * Grove, OK * 74344
918.786.5533 * www.grovedentalassociates.com

## ABOUT YOU

Date _____

Patient Name _____
(First) (Middle) (Last)

I prefer to be called _____

Sex (check one) □ Male □ Female Birthday _____

Address _____ City _____ State _____ Zip _____

Primary Phone # _____ Social Security # _____

Email _____ School _____ Grade_____

## PARENT/GUARDIAN INFORMATION

Father's Name _____ Father's SS # _____

Father's Employer _____ Phone: (Work #) _____ (Cell #) _____

Mother's Name _____ Mother's SS # _____

Mother's Employer _____ Phone: (Work #) _____ (Cell #) _____

Party Responsible for Payment: Full Name _____

Address _____City _____ State _____ Zip _____

Signature _____
*I understand that payment is expected on the day of each service. I realize I am also responsible for any remaining charges that my insurance company chooses not to pay.*

## DENTAL INSURANCE

*We will gladly assist you in filing the claims for your primary insurance if provided with the necessary information and a copy of the insurance card.*

□ Mark if Not Applicable Full Name of Policy Holder _____

Policy Holder: SS # _____ Birthday _____ Employer _____

Name of Insurance Company _____

Insurance Group # _____

## REFERRED BY

Name of Referral _____

Relationship to Referral _____

□ Phone Book □ Newspaper □ Facebook

□ Radio □ Website

□ Other _____

Bridging Dentistry and Wellness

*"Preventative measures, high quality care and good cooperation combined with timely treatment make it possible for most people to retain their natural teeth for a lifetime. Our staff is dedicated to this concept and with your cooperation we will do everything we can to help you reach your goals for dental health."*

# HEALTH QUESTIONNAIRE

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## DENTAL HEALTH INFORMATION

When was your last dental visit? _____

Who was your previous dentist? _____

Do you have sensitive teeth? □ Yes □ No

If so, what causes your tooth pain? _____

Do your gums bleed when you floss? _____

What (if anything) would you like to change about the appearance of your smile? _____

_____

Do you have any fears about visiting the dentist (pain, cost, previously bad experience, lack of time, etc.)?

_____

On a scale of 1 to 10 how would you rate your dental health? (1 being very poor, 10 being excellent)

Please circle one: 1 2 3 4 5 6 7 8 9 10

## MEDICAL INFORMATION

Name of Primary Physician _____

Date of last Dr.'s visit _____

List all medications you are currently taking _____

_____

List all medication allergies _____

Any recent illness? If so, please list _____

Are you Pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Do you have a history of any of the following? (Please check all that apply.)

- □ AIDS
- □ Anemia
- □ Arthritis
- □ Artificial Heart Valve
- □ Artificial Joints
- □ Asthma
- □ Back Problems
- □ Blood Thinners
- □ Cancer
- □ Chemical Dependency
- □ Chemotherapy
- □ Circulatory Problems
- □ Cortisone Treatments
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Headaches
- □ Heart Murmur
- □ Heart Problem(s)
  Describe _____
- □ Hemophilia
- □ Hepatitis
- □ High Blood Pressure
- □ HIV Positive
- □ Jaw Pain
- □ Kidney Disease
- □ Latex Allergy
- □ Liver Disease
- □ Mitral Valve Prolapse
- □ Nervous Problems
- □ Pacemaker
- □ Phen-fen or Diet Pills
- □ Prolonged Bleeding
- □ Psychiatric Care
- □ Radiation Treatment
- □ Respiratory Disease
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Seizures
- □ Shortness of Breath
- □ Stroke
- □ Swelling of Feet/Ankles
- □ Thyroid Problem
- □ Tobacco Habit
- □ Tuberculosis
- □ Ulcer
- □ Venereal Disease

Other _____