

## ABOUT YOU

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ ☐ Female ☐ Male  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ Driver License No.: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Position: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
Marital Status: ☐ Single ☐ Married ☐ Widowed Spouse's Work Phone: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ Spouse's Cell Phone: \_\_\_\_\_  
Spouse's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Spouse's SSN: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_  
Children's Names & Ages: \_\_\_\_\_

Whom may we thank for referring you: \_\_\_\_\_

## TELL US ABOUT YOUR MEDICAL HISTORY

Name of personal physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Approximate date of last visit: \_\_\_\_\_ Current health condition: ☐ Excellent ☐ Good ☐ Fair ☐ Poor  
Have you had any serious health problems in the last five years? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

(For women) Are you currently pregnant: ☐ Yes ☐ No If yes, If yes, how many months? \_\_\_\_\_

Do you take any vitamin or herbal supplements: ☐ Yes ☐ No If yes, If yes, what kind: \_\_\_\_\_

Are you currently taking: A beta-blocker: ☐ Yes ☐ No A monoamine oxidase inhibitor (MAOI) ☐ Yes ☐ No

Please list any other prescription medications and their purpose: \_\_\_\_\_

When was your last blood pressure reading? \_\_\_\_\_ What was it? \_\_\_\_\_

Please indicate if you currently have or have ever been treated for the following:

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Open Heart Surgery	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Surgery With Pins
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Artificial Valve	<input type="checkbox"/> Prosthetic Implant	<input type="checkbox"/> Artificial Joints

The following conditions may require a pre-medication. Please check if any of these apply to you:

<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Abnormal Blood Pressure	<input type="checkbox"/> Family History of Diabetes	<input type="checkbox"/> Excessive Urination	<input type="checkbox"/> Asthma
<input type="checkbox"/> AIDS / ARC	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Fainting Spell	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Cancer
<input type="checkbox"/> Depression	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Transplant Surgery	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Heart Attack / Stroke	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Tumor
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Seizures
<input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> Psychiatric Condition	<input type="checkbox"/> Drug / Alcohol Abuse	<input type="checkbox"/> Bruise Easily

Please check if you're allergic to any of the following:

<input type="checkbox"/> Local anesthetics	<input type="checkbox"/> Codeine or Other Narcotics	<input type="checkbox"/> Latex Sensitivity	<input type="checkbox"/> Shellfish, Iodine or
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Sedatives, Sleeping Pills	<input type="checkbox"/> Red Wine
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other: _____		

## EMERGENCY INFORMATION

Person to contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Address: \_\_\_\_\_

## INSURANCE INFORMATION

Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you.

Please bring your dental card with you to your appointment.

Subscriber to Insurance: (Last Name, First Name) \_\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN and/or Insurance ID# \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Insured is Through: \_\_\_\_\_ Phone: \_\_\_\_\_

## DENTAL HISTORY

What prompted you to call our office? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Previous dentist's name: \_\_\_\_\_

What did you like or dislike about your last dental experience? \_\_\_\_\_

How do you rate your smile from 1-10 (1 being not pleased and 10 being very pleased)? \_\_\_\_\_

What single thing would you most want to change about your teeth? \_\_\_\_\_

## PLEASE READ AND SIGN BELOW:

When a health care worker is exposed to my blood or body fluids through a needle stick, cut, or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases including but not limited to Hepatitis B and C virus and human Immunodeficiency Virus (AIDS).

Initial: \_\_\_\_\_

*I certify that the above information is accurate and true to the best of my knowledge. I also understand:*

- As a condition of treatment, all financial arrangements must be made in advance.
- If I have dental insurance, all dental services furnished are charged directly to me and I am personally responsible for payment of all dental services.
- Any claims not paid by my dental insurance within 60 days of treatment is due immediately.
- Any treatment diagnosed is only an estimate of services and under some circumstances the treatment may become more extensive and have additional charges.
- Utica Dental may make alterations to my treatment should the need arise. The office will make every effort to explain any treatment changes and their associated fees before continuing.
- All treatment fees presented will be honored for 6 months.
- Utica Dental or team members have permission to contact me by telephone at my home or work to discuss my treatment, insurance, or account.

Signature of patient, parent, or guardian \_\_\_\_\_ Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Signature of patient, parent, or guardian \_\_\_\_\_ Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**Utica Dental - "Best of the Best "Dentist" with Oklahoma magazine 2011, 2012"**  
**"#1 Lumineer Provider of Tulsa 2009, 2010, 2011" "Top 100 Invisalign Case for 2011"**  
**"2009 1st Place Winner - Best Invisalign Case Nationwide"**