CONFIDENTIAL PATIENT INFORMATION

Sean Tahaney, D.D.S.

Today's Date ____ / ____ / ________

Name ________________________________ Address ____

City ______________________ State _____ Zip __________

Physician ____

Employment ____

Birth Date ____ / ____ / ________

Email Address ____

Phone **Cell?**

Primary _____ - _____ - _______ ☐

Alternate _____ - _____ - _______ ☐

Marital Status _________________________

Welcome to our office! Please circle the correct answer:

Reason for dental visit? ____

Are you being treated for any condition by a physician?	Yes	No
Are you taking any medications?	Yes	No
If yes, please list medications: ____		
____		
Has there been any change in your health in the last 5 years?	Yes	No
Have you ever been seriously ill or had any major operations?	Yes	No
Do you require antibiotics before having dental treatment?	Yes	No

Please circle any of the following conditions you have or have had:

Seizures	Hemophilia	Ulcers / Dry Mouth
Fainting	Heart Problems	Kidney Problems
Nervousness	Angina	Venereal Disease
Stroke	High Blood Pressure	Diabetes
Glaucoma	Rheumatic Fever	Thyroid Problems
Cold Sores	Heart Murmur	AIDS/HIV Positive
Emphysema	Mitral Valve Prolapse	Arthritis
Tuberculosis	Congenital Heart Problems	Painful Jaw Joints
Asthma	Heart Surgery	Prosthetic Joints
Hay Fever	Prosthetic Heart Valve(s)	Hives
Sinus Problems	Pacemaker	Steroid Medication
Anemia	Blood Transfusion(s)	Drug Addiction
Blood Disease	Liver Disease	Alcoholism
Bleed Easily	Hepatitis: Type___________	Cancer / Radiation

Do you have any disease, condition, or problem not listed above? If so, what? ______________________________

____

Please circle if you have had an unusual reaction to any of the following:

Penicillin	Sulfa	Narcotics
Other Antibiotics	Iodine	Aspirin
Dental Anesthetic	Codeine	Latex
Sulfites	Other Medications	Metals

Do you ever have chest pain?	Yes	No
Do you ever have trouble with infections?	Yes	No
Do you smoke now, or do you have a history of smoking?	Yes	No
Females Only ---- Are you, or might you be pregnant? Nursing?	Yes	No
Are you taking birth control pills?	Yes	No

Persistent swollen glands in neck?	Yes	No
Have you ever had excessive bleeding from a tooth extraction or other wound?	Yes	No
Have you ever had an injury to your face or jaw?	Yes	No
Have you ever had surgery or x-ray treatment for a tumor, growth, or other condition in your mouth or throat?	Yes	No
Do you have sensitive teeth?	Yes	No
Have you had a toothache recently?	Yes	No
Do you have bleeding gums?	Yes	No

Please circle the fluorides you have had:

In Water   By Tablet   Topical (placed on teeth)   In Toothpaste

Approximately how long has it been since your last dental visit? ___________________

Who may we thank for your referral to our office? ______________________________

PERSON RESPONSIBLE FOR ACCOUNT:

Name ____

Address ____

City _________________________ State _____ Zip ___________

Relationship ___________________ SSN ______ - ____ - ________

Phone **Cell?**

Primary _____ - _____ - _______ ☐

Alternate _____ - _____ - _______ ☐

Driver's Lic. No. __________________________

PRIMARY DENTAL INSURANCE INFORMATION:

Employee Name ____

Employer ____

Address ____

City ___________________________ State ____ Zip __________

Phone _____ - _____ - _______

Employee DOB ____ / ____ / ________

Employee SSN ______ - ____ - ________

Insurance Co ___________________________

Program/Policy # ___________________________

Group ___________________________

SECONDARY DENTAL INSURANCE INFORMATION:

Employee Name ____

Employer ____

Address ____

City ___________________________ State ____ Zip __________

Phone _____ - _____ - _______

Employee DOB ____ / ____ / ________

Employee SSN ______ - ____ - ________

Insurance Co ___________________________

Program/Policy # ___________________________

Group ___________________________

RELEASE:

I, ____________________________________, have received a copy of Oxford Family Dentistry's "*Notice of Privacy Practices*."

I authorize release of my (or my child's) protected health care information to carry out treatment, payment activities, and healthcare operations.

I authorize Oxford Family Dentistry / Dr. Tahaney to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I hereby authorize payment of insurance benefits directly to Oxford Family Dentistry / Dr. Tahaney, otherwise payable to me.

I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

Patient's or Guardian's Signature____ Date________________________

* I authorize the use of specific treatment information on my answering machine and/or reminder cards for upcoming dental appointments (e.g., "You have a ***dental cleaning*** appointment on date/time," or, "Please remember to take your ***premedication***."   Yes   No