ONEIDA FAMILY DENTAL

YOUR INFORMATION

Today's Date: _____ MALE FEMALE

NAME: _____ Name I prefer to be called: _____

Birthdate: _____ SSN: _____

Driver's License #: _____ Email: _____

Address: _____ City/State/Zip: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Would you like to receive appointment correspondence via text: ☐ Yes ☐ No

Marital Status: Single Married Separated Divorced Widowed

Whom May We Thank for Referring You: ___ Google ___ Facebook ___ Location ___ Other: _____

Emergency Contact:

His/Her Name: _____ Relation: _____ Phone: _____

Address: _____ City/State/Zip: _____

Person Responsible for Account if Other than Yourself:

Name: _____ Relation: _____ Phone: _____

Address: _____ City/State/Zip: _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Insured's Name: _____	Insured's Name: _____
DOB: _____ SSN: _____	DOB: _____ SSN: _____
Employer: _____	Employer: _____
Insurance Company: _____	Insurance Company: _____
Insurance Address: _____	Insurance Address: _____
Phone #: _____	Phone #: _____
Group #: _____	Group #: _____
ID#: _____	ID#: _____

I hereby agree that I have been given the opportunity to review the Notice of Privacy Practices:

Name: _____ Date: _____

Consent for Treatment

The undersigned hereby authorizes the doctor or designated staff of Oneida Family Dental to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon diagnosis, the undesigned authorizes Oneida Family Dental to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. The undersigned agrees to the use of anesthetics, sedatives and other medication as necessary. The undersigned understands he/she may ask for a complete recital of any possible risk of complications.

Name: _____ Date: _____

Appointment Policy

Your appointment is time that has been reserved especially by you, for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $75 per scheduled hour cancellation fee.

Name: _____ Date: _____

Financial Information

Deductible, co-payments, and any position not covered by your insurance is due at the time of your visit.

We accept cash, personal check, Visa, MasterCard, Discover, AMEX, and Care Credit. If you are unable to pay in full at time of your visit, please speak with a receptionist prior to your treatment. Oneida Family Dental offers a 10% accounting courtesy for all treatment paid in full by check or cash. We offer a 7% account courtesy for all treatment that is paid in full by Credit or Debit Card at the time of service.

A $25 fee will be charged to the account for all returned checks.

Insurance: The undersigned requests and authorizes insurance benefits to be paid directly to the dentist. The undersigned also authorizes the release of the information, by Oneida Family Dental and the insurance company, necessary to process claims, or collect payment. The undersigned understands that he/she is financially responsible for any balance. **Any estimates given are not a guarantee of payment by the undersigned's insurance**. I have read and understand all stated financial policies.

Name: _____ Date: _____

MEDICAL HISTORY

It is important that we know your medical and dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone without consent. Thank you for filling out this questionnaire.

What is the reason for your visit today? _____

How long has it been since you saw a dentist? _____
Do you wear Dentures: Y N
Do your gums bleed or feel tender or irritated Y N
Do you have headaches, ear aches, or neck pains? Y N
Do you have a problem with bad breath? Y N

Your Current Dental Health is: Good Fair Poor
Would you like to know more about permanent replacements? Y N
Are you aware of GRINDING or CLENCHING your teeth? Y N
Have you worn braces on your teeth? (Orthodontics) Y N
How many times a day do you brush your teeth? _____ Floss? _____

Are your teeth sensitive to: (Circle one) HOT COLD SWEETS PRESSURE
What would you like to change about your smile? _____
Are you interested in whitening your teeth? Y N
Have you had a bad dental experience in the past? Y N If yes, explain: _____
What do we need to be aware of that may stand in your way of receiving treatment?
_____
Name of your previous Dentist._____

Do you or have you used products containing tobacco? Y N # of packs per day _____ # of years _____
Do you or have you used alcoholic drinks? Y N # of drinks per day _____ # of drinks per week _____ # of drinks per month _____
Recreational Drugs (such as marijuana or cocaine): Y N If yes, which ones: _____
Do you have any current health problems? Y N If yes, explain: _____
Are you under a physician's care now? Y N If yes, explain: _____
Are you currently taking any medication? Y N If yes, explain: _____
Are you allergic or have you reacted adversely to any of the following medications? Please circle Yes or No

Aspirin	Y N	Codeine	Y N	Erythromycin	Y N
Latex	Y N	Penicillin	Y N	Sulfa	Y N
Percodan	Y N	Darvon	Y N	Local Anesthetic	Y N
Valium	Y N	Nitrous Oxide	Y N		

Other: _____

Do you or have you experienced the following? Place a ✓ to all that apply.

Loss of Appetite	Fever	Fatigue	Weight gain
Weight Loss	GERD/Heartburn/Indigestion	Diarrhea	Nausea/Vomiting
Jaundice	Abdominal Pain	Cough	Asthma
Wheezing	Poor Exercise Tolerance	Bed Wetting	Frequent Urination
Difficulty Urinating	Blood in Urine	Erectile Dysfunction	Sneezing
Runny Nose	Itchy Eyes/Nose/Hives	Hay Fever	Nasal Congestion
Blurry Vision	Double Vision	Vision Loss	Palpitations
Chest Pain	Daytime Shortness of Breath	Ankle Swelling	Unusual Moles
Rash	Dryness	Heat Intolerance	Excessive Thirst
Constipation	Cold Intolerance	Cold Hands/Feet	Decreased Libido
Stiff/Sore Joints	Muscle Pain	Red or Swollen Joints	TMJ
Hearing Loss	Sore Throat	Sinus Congestion	Hoarseness
Weakness	Seizures	Involuntary Tongue Biting	Passing Out
Dizziness	Headaches	Numbness	Restless Leg Syndrome
Excessive Stress	Memory Loss	Difficulty with Focus	Trouble Concentrating
Hallucinations	Nervousness	Radiation/Chemo:	High Blood Pressure
Heart Disease	Heart Attack	Stroke	Congestive Heart Failure
Depression	Diabetes	Overweight/Obesity	Snoring
Sleep Apnea	Anxiety	Chronic Insomnia	Multiple Sclerosis
Sleep Walking	Anemia	Arthritis	Artificial Joints
Blood Disease	Cancer	Epilepsy	Excessive Bleeding
Fainting	Glaucoma	Head Injuries	Heart Murmur
Hepatitis	HIV	Kidney Disease	Liver Disease
Mental Disorders	Nervous Disorders	Pacemaker	Pregnant
Respiratory Problems	Rheumatic Fever	Rheumatism	Stomach Problems
Tuberculosis	Tumors	Ulcers	Venereal Disease

Other: _____

Reviewed By: _____