opencare DENTAL

Name:____
Date of Birth:____________SSN #_________________
Spouse's Name: __________________________________
Address:____
City/State__________________ Zip Code____________
Phone #:____
Email:____
Emergency Contact Name:__________________________
Phone #:____

Medical Health History: Do you have or have had any of the following?(Please check any that apply)

- ☐ Diabetes Type1 or Type 2 A1C:__________
- ☐ Dementia
- ☐ Alzheimer's Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Attack/ Angina/ Murmur/ MVP/ Defect
- ☐ Pacemaker
- ☐ Cancer or Tumor Type________Year________
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Artificial Joints Type________Year________
- ☐ Artificial Heart Valves or Endocarditis
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Neuropathy **OR** Fibromyalgia
- ☐ Osteoporosis **OR** other Bone Disorder
- ☐ Epilepsy, Seizures **OR** Fainting Spells
- ☐ Depression **OR** Anxiety
- ☐ Cold Sores/Herpes
- ☐ AIDS, HIV
- ☐ Arthritis
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Anemia or Blood disorders or Abnormal Bleeding
- ☐ Seasonal Allergies
- ☐ Alcoholism
- ☐ Acid Reflux
- ☐ Insomnia **OR** Trouble Sleeping
- ☐ Sleep Apnea
- ☐ Headaches
- ☐ Wake up Frequently OR Frequent Night Urination
- ☐ Other medical condition not listed?

  ____

Do you wear a C-PAP? Or have you worn one in the past?
☐Yes ☐No **If yes, how often?**________________
Have you been told you snore? ☐Yes ☐No
Have you had a sleep study or been told to have one?
☐Yes ☐No
Are you PREGNANT or could be pregnant?
☐Yes ☐No If yes, expected due date?___________
Do you smoke or use chewing tobacco?
☐Yes ☐No If yes, how often?__________________

Insurance Billing Information:
Dental Insurance Company_______________________
ID#_______________________Group #______________
Medical Insurance Company______________________
ID#_______________________Group #______________
Employer:______________________________________
How did you hear about our office?______________
Reason for today's visit________________________

Are you taking any of the following medications? (Please check all that apply)

<u>Anticoagulant</u>
☐Aspirin ☐ Plavix ☐ Coumadin/Warfarin
☐Other____

<u>Bisphosphonates for Osteoporosis</u>
☐Actonel ☐Fosamax ☐Boniva ☐Other_______________

<u>High Blood Pressure</u>
☐Lisinopril ☐Metoprolol ☐Atenolol ☐Furosemide ☐Losartan
☐Diovan ☐Hydrochlorothiazide ☐Amlodipine
☐Other_____________________________

<u>Diabetes</u>
☐Metformin ☐Actos ☐Insulin Shots ☐Other____________

<u>Thyroid Condition</u>
☐Synthroid(Levothyroxine) ☐Other_________________

<u>Asthma</u>
☐Singulair ☐Advair ☐Other________________________

<u>Pain Management</u>
☐Hydrocodone ☐Oxycodone ☐Lyrica ☐Celebrex
☐Neurontin(Gabapentin) ☐Other___________________

<u>High Cholesterol</u>
☐Zocor(Simvastatin) ☐Lipitor(Atorvastatin) ☐Crestor
☐Other____

<u>Anxiety or Depression</u>
☐Lexapro ☐Valium ☐Prozac ☐Xanax ☐Other__________

<u>Acid Reflux</u>
☐Nexium ☐Zantac ☐Omeprazole ☐Other_____________
Any other medications not listed?

____

Do you have any allergies to the following?
☐Latex ☐Penicillin ☐Local anesthetics ☐Sulfa Drugs
☐Sedatives ☐Aspirin ☐Codeine or Narcotics
☐Other____
Pharmacy Name:_______________________________
Address:_____________________________________

Patient Signature: ____________________Date:________
Doctor Signature: ____________________Date:________

Updated

Patient Signature: ____________________Date:________
Doctor Signature: ____________________Date:________