ora dental

PATIENT NAME_____

Patient Information *(confidential)*

Birth date _____

Home Ph (_____)_____ Work Ph (_____)_____ Cell Ph (_____)_____

Address _____

City _____ Postal Code _____

Email _____

Name of Physician _____ Phone # (_____)_____

Person to Contact in Case of Emergency: _____ Phone # (_____)_____

How did you find out about us? _____

Insurance Information *(please provide a copy of your insurance card)*

Name of Policy Holder _____ Birth date _____
Policy Holder's Employer _____
Name of Insurance Company _____ Group/Policy # _____ ID# _____

Do You Have Additional Insurance? □ Yes □ No If yes, please complete the following:
Name of Policy Holder _____ Birth date _____
Policy Holder's Employer _____
Name of Insurance Company _____ Group/Policy # _____ ID# _____

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing? □ Yes □ No
2. Are your teeth sensitive to hot or cold temperatures? □ Yes □ No
3. Are your teeth sensitive to sweet or sour liquids/foods? □ Yes □ No
4. Do you feel pain in any of your teeth? □ Yes □ No
5. Do you have any sores or lumps in or near your mouth? □ Yes □ No
6. Have you had any head or neck injuries? □ Yes □ No
7. Have you experienced any of the following problems in your jaw? □ Yes □ No
   - □ Clicking
   - □ Difficulty in opening or closing
   - □ Pain (joint, ear, side of face)
   - □ Difficulty in chewing
8. Do you have frequent headaches? □ Yes □ No
9. Do you clench or grind your teeth? □ Yes □ No
10. Do you ever wake from sleep with shortness of breath? □ Yes □ No
11. Have you had any difficult extractions in the past? □ Yes □ No
12. Have you ever had any prolonged bleeding following extractions? □ Yes □ No
13. Have you had any orthodontic treatment? □ Yes □ No
14. Do you wear dentures or partials? □ Yes □ No
    If yes, date of placement _____
15. Have you ever received oral hygiene instructions for the care of your teeth and gums? □ Yes □ No
16. Do you feel nervous about having dental treatment? □ Yes □ No
    If yes, why? _____
17. Do you like your smile? □ Yes □ No

Please continue with the reverse side of this form.

Patient Medical History

1. Are you under medical treatment now? □ Yes □ No
2. Have you been hospitalized within the last 5years? □ Yes □ No
   If yes, please explain _____
3. Are you taking any medications including non-prescription medicine? □ Yes □ No
   If yes, what medications are you taking? _____
   _____
   _____
4. Have you lost or gained more than 10 lbs in the past year? □ Yes □ No
5. When you walk up stairs, do you have to stop because of chest pain, shortness of breath? □ Yes □ No
6. Do your ankles swell during the day? □ Yes □ No
7. Are you on a special diet? □ Yes □ No
8. Do you have or have you had any of the following? *(please circle)*

Sinus Trouble	Diabetes Type I or II	Stroke
Arthritis	Radiation Therapy	Heart Pacemaker
Cortisone Medication	Chemotherapy	Artificial Joint Replacement
Glaucoma	Leukemia	Rheumatic Fever
Sickle Cell Disease	Cancer	Ulcers
Anemia	Epilepsy or Seizures	Stomach Troubles/GERD
Hemophilia	Fainting or Dizzy Spells	Kidney Trouble
Bruise Easily	Nervousness	Thyroid Disease
Hepatitis A (infectious)	Psychiatric Treatment	Emphysema/COPD
Hepatitis B (serum)	Chest Pains (Angina Pectoris)	Tuberculosis
Hepatitis C	Easily Winded	Asthma
Liver Disease	Swollen Ankles	Scarlet Fever
Jaundice	Heart Attack (Myocardial Infarction)	Cold Sores
Blood Transfusion	Artificial Heart Valve	STD / Venereal Disease
Drug Addiction	Mitral Valve Prolapse	Hay Fever
AIDS-HIV positive	Congenital Heart Lesions	
High Blood Pressure	Heart Failure/Disease	Other _____
Low Blood Pressure	Heart Surgery	

9. Are you **allergic** to or have you had a reaction to any of the following: *(please circle)*

Local Anesthetics (ie. Novocain)	Sedatives	Any Metals (ie. Nickel, mercury, etc.)
Penicillin or Other Antibiotics	Iodine	Latex Rubber
Sulfa Drugs	Aspirin	Other _____
Barbiturates	Codeine	

10. **Women Only:**
Are you Pregnant or Nursing? □ Yes □ No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I acknowledge that I will be given the opportunity to discuss any treatment and can question the dentist concerning the nature, inherent risks, and the alternatives to any treatment, and will be given satisfactory answers. I am aware the practice of dentistry is not an exact science and acknowledge that no promises or guarantees of results have been made nor are expected. I hereby acknowledge that unforeseen conditions may arise during my treatment that may require a different procedure than originally discussed. I hereby authorize Dr. Chun to perform such procedures when, in his professional judgement, they may be necessary.

Please note that we do require 2 business days notice if you need to make any changes to your scheduled appointment. Failure to do so will result in a $50.00 short notice cancelation or missed appointment fee. We understand circumstances may vary.

I authorize Ora Dental to send me correspondence (eg, appointment reminders) via Electronic Message (ie., email, SMS, etc.)
□ **Yes** □ **No** **x**_____ (initials)

X_____ **Date** _____

Signature of patient (or guardian if min