# Oceans Dental, P.C.

## Bruce A. Condello, D.D.S.

## 1. About You

Today's Date: _____

Name: _____
Last First MI Mr Mrs Ms Dr

I prefer to be called: _____ ❒ Male ❒ Female

Birthdate: ___/___/___ Age: _____ SS#: _____

Home Address: _____

_____

_____
City State Zip

❒ Single ❒ Married ❒ Divorced/Separated ❒ Widowed

Home Ph: (_____) _____ Cell / Other: _____

Work Ph: (_____) _____ Ext. ____ DL # _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

How do you like to be contacted? _____

Whom may we thank for referring you? _____

Previous / Present Dentist: _____

Last Visit to Dentist: _____

Person Responsible for Account _____

## 3. Spouse Information

His/Her Name: _____

Employer: _____

Birthdate: ___/___/___ Age: _____ SS#: _____

Work Ph: (_____) _____ Ext. ____ DL # _____

## 2. Dental Insurance

### Primary Insurance

Do you have dental insurance? ❒ Yes ❒ No

Insured's Name: _____

Insured's Birthdate: ___/___/___ Insured's SS#: _____

Relationship: _____

Insured's Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Phone #: _____

Insured's ID #: _____

Group #: _____

### Secondary Insurance

Insured's Name: _____

Insured's Birthdate: ___/___/___ Insured's SS#: _____

Relationship: _____

Insured's Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Phone #: _____

Insured's ID #: _____

Group #: _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Oceans Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Relationship to Patient: _____

## 4. Medical History

Name: _____
Last First MI Mr Mrs Ms Dr

Birthdate: ____/____/____

Do you have a personal physician? ❒ No ❒ Yes

Physician's Name: _____

Phone #: (____) _____Date of Last Visit: _____

Your current physical health is: ❒ Good ❒ Fair ❒ Poor

Are you currently under the care of a physician: ❒ No ❒ Yes

Please explain _____

Do you require antibiotics before dental treatment? ❒ No ❒ Yes

Do you smoke or use tobacco in any other form? ❒ No ❒ Yes

Are you taking any prescription / over-the-counter drugs?
❒ No ❒ Yes

Please list each one:_____

_____

_____

Treatment or Medication for Osteoporosis? ❒ No ❒ Yes

Are you pregnant? ❒ No ❒ Yes Week #: _____

Are you nursing? ❒ No ❒ Yes

Treating Physician: _____

Have you ever had any of the following diseases or medical problems:

Y N Abnormal Bleeding / Hemophilia
Y N Addison's Disease
Y N AIDS
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Asthma
Y N Cancer / Chemotherapy
Y N Depression / Anxiety
Y N Diabetes
Y N Difficulty Breathing
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Healing Complications
Y N Heart Attack / Heart Surgery
Y N Heart Disease
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N HIV +
Y N Hospitalized for Any Reason
Explain: _____
Y N Joint Replacement
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Pacemaker
Y N Psychological Disorders
Explain: _____
Y N Radiation Treatment
Y N Respiratory Disease
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Sinus Problems
Y N Stroke
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

_____

Are you allergic to any of the following?:

Y N Aspirin Y N Erythromycin Y N Penicillin
Y N Codeine Y N Jewelry/Metals Y N Tetracycline
Y N Dental Anesthetics Y N Latex Y N Other
Y N Sulfa

Please list any other drugs/materials that you are allergic to: ___

_____

_____

## 5. Dental History

Why have you come to the dentist today? _____

_____

Do you have any dental concerns? ❒ No ❒ Yes

If yes, please explain _____

_____

Are you currently in pain? _____ ❒ No ❒ Yes

Your current dental health is: ❒ Good ❒ Fair ❒ Poor

Have you ever had a serious / difficult problem associated with any previous dental work? ❒ No ❒ Yes

Please explain: _____

_____

Have you ever had periodontal disease? (gum disease)
❒ No ❒ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint? (TMJ / TMD)? ❒ No ❒ Yes

Are your teeth sensitive to heat, cold, or anything else? _____

_____

Do you have any loose teeth? ❒ No ❒ Yes

Do you still have wisdom teeth? ❒ No ❒ Yes

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____
Signature Date

Relationship to Patient: _____