Utica Dental
Life Changing Smiles

Utica Dental
1720 S. Utica Ave. • Tulsa, OK 74104
918-712-0000
www.uticadental.com

ABOUT YOU

Today's Date: _____

Name: _____ ❑ Female ❑ Male

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: ____/____/____ SSN: _____ Driver License No.: _____

E-mail Address: _____

Employer: _____

Position: _____

Business Address: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed Spouse's Work Phone: _____

Name of Spouse: _____ Spouse's Cell Phone: _____

Spouse's Birth Date: ____/____/____ Spouse's SSN: _____

Spouse's Employer: _____

Children's Names & Ages: _____

_____

Whom may we thank for referring you: _____

TELL US ABOUT YOUR MEDICAL HISTORY

Name of personal physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Approximate date of last visit: _____ Current health condition: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Have you had any serious health problems in the last five years? ❑ Yes ❑ No If yes, please explain: _____

_____

(For women) Are you currently pregnant: ❑ Yes ❑ No If yes, If yes, how many months? _____

Do you take any vitamin or herbal supplements: ❑ Yes ❑ No If yes, If yes, what kind: _____

Are you currently taking: A beta-blocker: ❑ Yes ❑ No A monoamine oxidase inhibitor (MAOI) ❑ Yes ❑ No

Please list any other prescription medications and their purpose: _____

_____

When was your last blood pressure reading? _____ What was it? _____

Please indicate if you currently have or have ever been treated for the following:

❑ Heart Murmur	❑ Open Heart Surgery	❑ Rheumatic Fever	❑ Surgery With Pins
❑ Mitral Valve Prolapse	❑ Artificial Valve	❑ Prosthetic Implant	❑ Artificial Joints

The following conditions may require a pre-medication. Please check if any of these apply to you:

❑ Abnormal Bleeding	❑ Blood Transfusion	❑ Emphysema	❑ Diabetes
❑ Abnormal Blood Pressure	❑ Family History of Diabetes	❑ Excessive Urination	❑ Asthma
❑ AIDS / ARC	❑ Epilepsy	❑ Arthritis	❑ Ulcers
❑ Kidney Trouble	❑ Fainting Spell	❑ Radiation Therapy	❑ Cancer
❑ Depression	❑ Tuberculosis	❑ Venereal Disease	❑ Jaundice
❑ Glaucoma	❑ Anemia	❑ Transplant Surgery	❑ Pacemaker
❑ Heart Attack / Stroke	❑ Heart Disease	❑ Hay Fever	❑ Tumor
❑ Hepatitis A	❑ Hepatitis B	❑ Hepatitis C	❑ Seizures
❑ Nervous Disorder	❑ Psychiatric Condition	❑ Drug / Alcohol Abuse	❑ Bruise Easily

Please check if you're allergic to any of the following:

❑ Local anesthetics	❑ Codeine or Other Narcotics	❑ Latex Sensitivity	❑ Shellfish, Iodine or
❑ Sulfa Drugs	❑ Aspirin	❑ Sedatives, Sleeping Pills	❑ Red Wine
❑ Penicillin	❑ Other: _____		

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____

Phone #: _____ Cell #: _____ Work #: _____

Address: _____

INSURANCE INFORMATION

Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you.

Please bring your dental card with you to your appointment.

Subscriber to Insurance: (Last Name, First Name) _____

D.O.B. _____/_____/_____ SSN and/or Insurance ID# _____

Name of Insurance: _____ Phone: _____

Employer Insured is Through: _____ Phone: _____

DENTAL HISTORY

What prompted you to call our office? _____

When was your last dental visit? _____

Previous dentist's name: _____

What did you like or dislike about your last dental experience? _____

How do you rate your smile from 1-10 (1 being not pleased and 10 being very pleased)? _____

What single thing would you most want to change about your teeth? _____

PLEASE READ AND SIGN BELOW:

When a health care worker is exposed to my blood or body fluids through a needle stick, cut, or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases including but not limited to Hepatitis B and C virus and human Immunodeficiency Virus (AIDS).

Initial: _____

I certify that the above information is accurate and true to the best of my knowledge. I also understand:

- As a condition of treatment, all financial arrangements must be made in advance.
- If I have dental insurance, all dental services furnished are charged directly to me and I am personally responsible for payment of all dental services.
- Any claims not paid by my dental insurance within 60 days of treatment is due immediately.
- Any treatment diagnosed is only an estimate of services and under some circumstances the treatment may become more extensive and have additional charges.
- Utica Dental may make alterations to my treatment should the need arise. The office will make every effort to explain any treatment changes and their associated fees before continuing.
- All treatment fees presented will be honored for 6 months.
- Utica Dental or team members have permission to contact me by telephone at my home or work to discuss my treatment, insurance, or account.

_____

Signature of patient, parent, or guardian Date Relationship to patient

_____

Signature of patient, parent, or guardian Date Relationship to patient