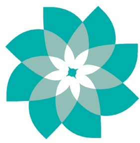

magnolia
FAMILY DENTISTRY

Leaha Nels DDS
101 North Douglas Boulevard, Suite T,
Midwest City, OK 73130

Welcome to our office! To assist us in serving you, please complete the following confidential form.

GENERAL INFORMATION

Patient's name ______________________________ Preferred name __________________ Date of birth _____________

If minor, legal guardian's name ____________________ Cell phone________________ Other phone ________________

Address ____ City ___________________ State ________ Zip ___________

Social Security number: _________________________ E-mail address _______________________________________

Would you like to receive appointment confirmations via text message? ☐ Yes ☐ No

How did you hear about our office? ☐ Mailer ☐ Search engine ☐ Driving by ☐ Facebook ☐ Live in area

☐ Current patient, please give their name so we may thank them. ______________________ ☐ Other ________________ ______________________

INSURANCE INFORMATION

Dental Insurance Company ___________________________ Group number/member ID ___________________________

Are you the policy holder? ☐yes ☐no If no, who? ____

Policy holder date of birth_________________ Policy Holder Social Security Number ______________________________

Do you have a secondary insurance? ☐yes ☐no Policy Holder name _____________________________________

Dental Insurance Company ___________________________ Group number/member ID ___________________________

Policy holder date of birth_________________ Policy Holder Social Security Number ______________________________

NOTICE OF PRIVACY PRACTICES

Acknowledgement of receipt of notice of privacy practices, you may refuse to sign this acknowledgement. I have received a copy of this office's Notice of Privacy Practices.

____ ________________________
signature of patient, or legal guardian if under 18 years Date

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FAMILY DENTISTRY

DENTAL PREFERENCES & HISTORY

We want get to know you, your concerns, goals and your preferences so we can customize our care to you.

Do you consider yourself a proactive person? (You prefer to avoid complications and take care of an issue immediately instead of letting it worsen over time and cost more time, visits, money, and/or pain down the road.)
☐yes ☐no

Do you consider yourself a reactive person? (You prefer to deal with any issues as the develop. Even if means it costs more time, visits, money, and/or pain down the road.)
☐yes ☐no

What do you most value concerning dental treatment?
☐ *Cosmetics*- how teeth look, you prefer straight and white teeth
☐ *Function*- the ability to enjoy your favorite food and drink
☐ *Comfort*- not being in pain or having sensitive teeth and gums
☐ *Longevity*- you want to have your natural teeth for the rest of your life

What best describes your biggest obstacle to visiting a dental office?
☐ *No obstacles*- you come regularly for dental hygiene appointments and value your dental health
☐ *Fear*- fear of pain, noises, environment, past experiences
☐ *Time*- unable to take time away from work or other commitments, prefer to get in an out of the office quickly
☐ *No urgency*- nothing hurts so you haven't seen the need to go to the dentist
☐ *Budget*- you know you need dental treatment but did not have the money to address the issues found
☐ *No trust*- bad dental experiences previously, felt ripped off, did not see the need for treatment

Are you currently experiencing dental pain? ☐yes ☐no
If so, please describe. ______________________________
____
Date of last dental visit ______________________________
Why did you leave your previous dentist? _____________
____
Do you prefer to receive nitrous (laughing gas) during dental treatment? ☐yes ☐no ☐don't know
Have you previously been diagnosed with gum disease? ☐yes ☐no

Do you clench/grind your teeth? ☐yes ☐no ☐don't know
Do you wear a nightguard? ☐yes ☐no
Do you experience dry mouth? ☐yes ☐no
Do you use tobacco? ☐yes ☐no
If so, what form? ________________________________
How often do you brush? _____________________________
How often do you floss? ______________________________
Do you consume sugary beverages (sodas, juices, etc…) or snack between meals? ☐yes ☐no
If so, how often? ________________________________

Are you happy with the appearance and health of your smile? ☐yes ☐no
If no, what are you unhappy with?

☐ bad breath
☐ color of teeth
☐ size/shape of teeth
☐ broken/chipped teeth
☐ dark fillings
☐ worn teeth
☐ missing teeth
☐ sensitive teeth
☐ stained teeth
☐ crooked teeth
☐ crowded teeth
☐ too much space
☐ loose teeth
☐ bleeding gums
☐ too much gum showing
☐ current dentures
☐ previous dental work
☐other _______________
____
____

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FAMILY DENTISTRY

MEDICAL HISTORY

Cardiovascular
- ☐ Heart murmur/damaged valve
- ☐ Heart stent or angioplasty
- ☐ Heart attack
- ☐ Stroke
- ☐ Angina, chest pain or discomfort
- ☐ Congestive heart failure
- ☐ Peripheral artery disease (PAD)
- ☐ Swollen ankles
- ☐ Bleeding/clotting problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular or rapid heart beat
- ☐ Heart pacemaker

Sleep
- ☐ Snoring
- ☐ Excessive daytime tiredness
- ☐ Poor sleep
- ☐ Gasp air/stop breathing during sleep
- ☐ Obstructive sleep apnea
- ☐ CPAP
- ☐ Oral sleep appliance

Gender Health
Female:
- ☐ Birth control pills
- ☐ Pregnant or planning pregnancy
- ☐ Nursing mother

Male:
- ☐ Erectile dysfunction

Cancer
- ☐ Cancer or tumor, oral cancer
- ☐ Chemo or radiation therapy
- ☐ HPV positive (Human Papilloma)
- ☐ Excessive sun exposure

Endocrine Disorders
- ☐ Thyroid problems
- ☐ Pituitary or adrenal problems
- ☐ Insulin resistant / Pre-diabetes
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Diabetes is controlled

Head & Neck
- ☐ Headaches (migraine or tension)
- ☐ Jaw joint popping or clicking
- ☐ Limited mouth opening
- ☐ Jaw, face, neck or back pain
- ☐ Ear problems or pain
- ☐ Mouth breather
- ☐ Hay fever or sinus problems
- ☐ Persistent sore throat/cough
- ☐ Chronic hoarseness
- ☐ Unexplained numbness or pain
- ☐ Mouth sores
- ☐ Dentures with persistent sores
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Difficulty moving jaw or tongue
- ☐ Lump, swelling in mouth or neck
- ☐ Numb mouth or tongue
- ☐ Ear pain

Other Disease & Conditions
- ☐ Liver disease or Hepatitis
- ☐ Tuberculosis
- ☐ AIDS / HIV positive
- ☐ Venereal disease
- ☐ Chronic fatigue / Fibromyalgia
- ☐ Arthritis or Rheumatism
- ☐ Kidney disease
- ☐ Osteoporosis (bone loss)
- ☐ Acid reflux / Heartburn (GERD)
- ☐ Frequent nausea / vomiting
- ☐ Gastrointestinal disease
- ☐ Ulcers, colitis or irritable bowel
- ☐ Lung disease
- ☐ Asthma
- ☐ Emphysema or COPD
- ☐ Epilepsy or Seizures
- ☐ Memory problems
- ☐ High stress or anxiety levels
- ☐ Depression
- ☐ Immune system disorder
- ☐ Sjogren's syndrome
- ☐ Any bleeding disorder
- ☐ Other (please list) ______________

____

____

Family Health History
- ☐ Heart disease
- ☐ Diabetes
- ☐ Stroke
- ☐ Dementia

Are you currently under a physician's care? ☐yes ☐no

Name of physician ________________________________

Have you ever taken bisphosphonates (ex: Fosamax, Boniva)? ☐yes ☐no

Do you have any artificial joints or heart valves? ☐yes ☐no

Are you allergic to or have you reacted adversely to any of the following?

- ☐ Latex materials
- ☐ Penicillin
- ☐ Local anesthetics
- ☐ Codeine
- ☐ Sulfa drugs
- ☐ Barbiturates or sedatives
- ☐ Other (include food allergies)

____

____

Please list current medications: ____

____

____

OFFICE AND PAYMENT POLICIES

The following is an outline of our office and payment policy, please read it carefully.

- Please notify our office when you have a change of address, phone number or insurance information.

Appointments

- When time permits, as a courtesy, we will call to confirm your appointment. However, it is the responsibility of the patient to keep or cancel the appointment whether or not we were able to make contact for confirmation.
- We request 48 hour notice when cancelling an appointment. Appointments cancelled with less than 48 hour notice will incur a fee of $75.00.
- If you have two or more short notice cancel or unattended appointments we will require a credit card on file or a refundable deposit prior to reserving an appointment time.

Insurance

- We will gladly file your insurance as a courtesy and accept assignment of benefits. However, if the insurance company does not pay after 60 days post treatment, it will be your responsibility to pay Magnolia Family Dentistry for the services and/or resubmit the insurance on your own.
- You are responsible for payment of any service applied to your deductible.
- You are responsible for payment of any amount over your annual maximum allowance, which includes dental services performed in the office, as well as any other offices.

Payment

- Total payment is due for services when treatment is rendered. We accept Visa, MasterCard, Discover, American Express, cash and check.
- There will be a $25 fee for all returned checks.
- Should your account be sent to collections you will be responsible for legal fees and associated costs.

Please inquire with our staff if you are uncertain about any subject outlined above. Your signature below will certify that you understand and will comply with this policy.

I, the undersigned, certify to the best of my knowledge the information given above is accurate and I have reviewed the Office and Payment Policies.
I authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids they deem appropriate to make a thorough diagnosis of my dental needs.

____ ______________________________
signature of patient , or parent if under 18 years date