Welcome to Olex Dental where our mission is to provide quality dental care while building lasting relationships with our clients for years to come. In order for us to know you better, we have put together this form to make the transition smoother. Please fill this form out completely. Be sure to read, sign and date our Financial Policies. Thank you.

NAME: _____ (FIRST / LAST / MIDDLE INITIAL) SS#: _____

ADDRESS: _____ (STREET / CITY/TOWN / ZIP)

HOME TEL: _____ WORK: _____ CELL: _____

DOB: _____ SEX: M F CIRCLE ONE: single married separated widowed other

PATIENT EMPLOYMENT: _____ (NAME / ADDRESS / TOWN/CITY)

IN CASE OF EMERGENCY: _____ TEL #: _____

IF YOU HAVE INSURANCE, PLEASE FILL OUT THE SECTION BELOW:

INS COMPANY: _____ ID #: _____ GROUP #: _____

SUBSCRIBER NAME: _____ DOB: _____

EMPLOYED BY: _____ (NAME OF EMPLOYER / ADDRESS / TOWN/CITY)

FORMER DENTIST: _____ TEL #: _____

ADDRESS: _____ (STREET / TOWN/CITY / ZIP)

LAST VISIT: _____ LAST CLEANING: _____ WERE X-RAYS TAKEN? : _____

PHYSICIAN: _____ TEL #: _____

ADDRESS: _____ (STREET / TOWN/CITY / ZIP)

WHAT BRINGS YOU TO OUR OFFICE? _____

OFFICE FINANCIAL POLICIES

1. At the end of each appointment, you will receive an estimated amount of your insurance co-pay or the amount due, if you do not have insurance. Full payment is due at the time of service. This is only an estimation of what insurance will not pay. Any balance due after insurance pays is the patient's responsibility. We accept all major credit cards, flex spending and Care Credit.
2. A fee of $35.00 will be charged for any returned checks.
3. As insurance policies vary, it is the patient's responsibility to check with their insurance company to understand their dental policy.
4. **CANCELLATION POLICY:** A 24-hour notice, during normal business hours, is required from the scheduled appointment time or a **$35.00 fee** will be applied to the account. This allows other patients the opportunity to be notified of the available appointment.

I HAVE READ/UNDERSTAND THE ABOVE FINANCIAL POLICIES.

Signature: _____ **Date:** _____

Please turn over to fill out the remainder of this form. Thank you

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD: (please circle one)

Kidney Disease	YES	NO	Tuberculosis	YES	NO
Hepatitis/Liver Disease	YES	NO	Asthma	YES	NO
High/Low Blood Pressure	YES	NO	Diabetes	YES	NO
Shortness of Breath	YES	NO	Swelling of Ankles	YES	NO
Artificial Joints	YES	NO	Stents	YES	NO
Heart Murmur/Pacemaker	YES	NO	Mitral Valve Prolapse	YES	NO
Anemia	YES	NO	Thyroid Disease	YES	NO
Rheumatic Fever	YES	NO	Frequent Nose Bleeds	YES	NO
AIDS/HIV	YES	NO	Cancer/Tumor	YES	NO
Epilepsy (Fainting Spells)	YES	NO	Radiation/Chemotherapy	YES	NO
Stomach Trouble/Ulcers	YES	NO	Unexplained Bruises	YES	NO
Psychiatric Treatment	YES	NO	Stroke	YES	NO

CIRCLE IF YOU HAVE ANY PROBLEMS WITH THE FOLLOWING:

Bad Breath	Food Collection Between Teeth	Growths In Mouth
Bleeding Gums	Grinding Or Clenching Teeth	Sensitivity To Hot/Cold
Clicking/Jaw Popping	Sensitivity To Sweets	Loose Teeth
Broken Filling(s)	Bad Taste In Mouth	Difficulty Chewing

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR TEETH?

_____

HAVE YOU EVER EXPERIENCED AN ADVERSE REACTION DURING OR IN CONJUNCTION WITH A MEDICAL OR DENTAL PROCEDURE? YES NO IF SO, WHEN? : _____

ARE YOU UNDER THE CARE OF A PERIODONTIST? YES NO
IF SO, WHO IS THE DOCTOR? : _____ TEL #: _____

DO YOU SMOKE? YES NO IF SO, HOW MANY PACKS PER DAY? : _____

DO YOU DRINK ALCOHOL? YES NO IF SO, HOW MANY DRINKS PER DAY? : _____ WEEK? : _____

LIST ANY MEDICATIONS THAT YOU CURRENTLY TAKE:

_____

_____

LIST ANY DRUG ALLERGIES THAT YOU HAVE:

_____

_____

(WOMEN) IS THERE A POSSIBILITY THAT YOU MAY BE PREGNANT? YES NO WHICH TRIMESTER? : _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? YES NO
IF SO, PLEASE EXPLAIN: _____

HAS YOUR PHYSICIAN RECOMMENDED ANTIBIOTICS BEFORE DENTAL TREATMENT? YES NO
IF SO, PLEASE EXPLAIN: _____

PLEASE LIST ANY MAJOR SURGERIES OR ILLNESSES: _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO DATES: _____

TO THE BEST OF MY KNOWLEDGE THE INFORMATION ON THIS QUESTIONNAIRE IS TRUE AND ACCURATE. I UNDERSTAND THIS WILL BE USED TO DETERMINE APPROPRIATE AND HELPFUL DENTAL TREATMENT. IF THERE IS ANY CHANGE TO MY MEDICAL STATUS, IT IS MY RESPONSIBILITY TO INFORM THE DENTIST AND STAFF.

SIGNED: _____ **DATE:** _____