O'Brien Dental Wellness Center

Dr. Michael O'Brien, DMD, NMD, IBDM
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Tulsa, OK 74137
Phone: (918) 477-9000 Fax: (918) 477-9056

PATIENT INFORMATION: **Today's date: _____**

Name (first/last):_____ Preferred Name: _____

***If minor, Guarantor's Name:* _____ *& Date of Birth:* _____**

Male _____ Female _____ Single _____ Married _____ Divorced _____ Widowed _____ Minor _____

Date of Birth: _____/_____/_____ Social Security #: _____

Home address: _____ City: _____ State: _____ Zip: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Place of Employment: _____

Who referred you to our office? _____

Major complaint or reason for today's visit: _____

_____

Have you been seen for this condition? Y or N Date: _____ What was done? _____

_____

In case of emergency, please notify:

Name: _____ Relationship: _____ Phone: _____

In consideration of the services rendered to me by this office, I am obligated to pay said office in accordance with its credit terms and policy. **All today's procedures are expected to be paid in full: credit card, check, cash, payment plans available via Care Credit.**

DENTAL INSURANCE INFORMATION

To be completed if you have Dental Insurance – *Medicare and Health* insurance do not pay for our services.

Please give your Dental Insurance card to the front desk person.

We will NOT be able to file dental insurance for you UNLESS we have a copy of the insurance card.

We do not accept assignment of insurance benefits; payment in full is due on the day of the appointment.

Primary Dental Insurance

Name of person that carries coverage: _____ D.O.B. _____

Dental Insurance Company: _____ Social Security/ID #: _____

All insurance re-imbursements will be paid directly to you.

Assignment & Release: I authorize the dentist to release any information required for this claim.

***Patient or Guarantor's signature:* _____**

Please complete the medical questionnaire on the back-side of this form

MEDICAL HISTORY

Primary Physician Name: _____ MD or DO or DC

Address (City/State): _____ Telephone: _____

Please **check** the following if it applies to you:
____ Ever had or have Hepatitis Type: ____ When: _____
____ Epilepsy
____ Rheumatic fever
____ Scarlet fever
____ Heart murmur or mitral-valve prolapsed
____ High blood pressure
____ Have you been told (by physician) to take an antibiotic prior to dental appointment
____ Diabetes Type: ____ Insulin dependent: Y or N Date diagnosed: _____
____ Cancer Type: _____ Date of Chemo: _____ or Radiation: _____
____ TIA or Stroke
____ Heart trouble Heart attack: Y or N Stent: Y or N Date: _____
____ Stomach ulcer
____ Thyroid disorder
____ Smoking How much per day: _____ How many years: _____ Quit? _____
____ Prolong bleeding due to procedures or a slight cut
____ Immune deficiency (AIDS or HIV)
____ Psychiatric treatment or emotional problems
____Bisphosphonates, history of taking
If you are **female**: pregnant: Y or N Taking birth control pills: Y or N Taking hormones: Y or N

Allergies or reaction to:
____ penicillin ____ aspirin ____ erythromycin ____ tetracycline ____ codeine
____ sedative ____ dental anesthetic ____ latex
____ other medication, list and describe: _____

Any type of disability; please describe: _____

List of current prescription medication: _____
(if lengthy, please provide on separate sheet)

Are you on a detox regimen? Y or N What: _____

Any other medical conditions not listed above: _____

Consent to Share Information

I consent for Dr. O'Brien to share my personal information, especially with regards to my dental diagnosis and treatment, with the following people and, if applicable, to my dental insurance company.

1. _____ 3. _____
2. _____ 4. _____

Print Patient Name: _____ Date: _____

Patient or Guardian Signature: _____