BUR-OAK DENTAL

ZACH SIEFRING, D.M.D.
440 BUR-OAK DRIVE
GREENVILLE, OHIO 45331
PH: 937-548-5496

PATIENT REGISTRATION FORM

Preferred Name: O Mr. O Mrs. O Miss O Dr.		
Name:		
Last	First	Middle
Home Phone #:	Cell Phone #:	
Address:		
Date of Birth:	SS#:	Sex: O M O F
Email:		
Emergency Contact:	Relationship:	Phone:
Employer:	Employer Phone:	
Employment Status: O Full Time O Part Time O Retired O Unemployed School Status: O Full Time O Part Time		
Marital Status: O Married O Divorced O Separated O Widowed O Single		
Preferred Pharmacy:	Location (city):	

DENTAL INSURANCE FORM

Name of Insured:	Relationship to Patient: O Self O Spouse O Parent O Other
Insured Social Security #:	Insured Birth Date:
Insured Employer:	
Insurance Company:	Insurance Company Phone #:
Address of Insurance Company:	Insurance ID #:
	Group ID#:

DENTAL HISTORY FORM

Please mark your response:					
	Y	N		Y	N
Do your gums bleed when you brush/floss?	O	O	Do you brux or grind your teeth?	O	O
Have you had previous periodontal (gum) treatment?	O	O	Do you have clicking/popping/discomfort?	O	O
Do you suffer from dry mouth?	O	O	Do you suffer from frequent headaches/earaches?	O	O
Do you frequently get sores or ulcers in your mouth?	O	O	Do you wear dentures or partials?	O	O
Have you had previous orthodontic (braces) treatment?	O	O			
Date of last dental exam?					
Date of last dental x-rays?					
Are you currently experiencing any dental pain?					
How do you feel about your smile?					
Reason for appointment?					

I certify that that I have read and understand the above and that the information given on this form for self or given by legal guardian is accurate:
Signature: Date:

BUR-OAK DENTAL

ZACH SIEFRING, D.M.D.
440 BUR-OAK DRIVE
GREENVILLE, OHIO 45331
PH: 937-548-5496

MEDICAL HISTORY FORM

Are you currently under the care of a physician?	
Physician Name:	Office Location (city):
Date of last physical exam:	
Have you had a serious illness or been hospitalized in the last 3 years: If yes, what was the illness or problem?	

Are you allergic or have any reaction to the following?	Y	N
Codeine or other narcotics	O	O
Latex	O	O
Local Anesthetics	O	O
Metals	O	O
Penicillin	O	O
Sulfa drugs	O	O
Other:		

For Women Only:	Y	N
Pregnant?	O	O
Number of weeks:		
Birth control or hormone replacement?	O	O
Nursing?	O	O

Do you have, or have had, any of the following?								
	Y	N		Y	N		Y	N
Alcohol abuse	O	O	Epilepsy	O	O	Mitral Valve Prolapse	O	O
Alzheimer's Disease	O	O	Fainting Spells	O	O	Pacemaker	O	O
Anemia	O	O	Glaucoma	O	O	Pre-med needed for treatment	O	O
Angina	O	O	HIV/AIDS	O	O	Psychiatric Treatment	O	O
Arthritis/Rheumatism	O	O	Heart Attack	O	O	Radiation Therapy	O	O
Artificial Heart Valve	O	O	Heart Disease	O	O	Rheumatic Fever	O	O
Asthma	O	O	Heart Murmurs	O	O	Seizures	O	O
Bisphosphonate Usage	O	O	Heart Surgery	O	O	Shingles	O	O
Blood Transfusion Therapy	O	O	Hemophilia	O	O	Sinus Problems	O	O
Chemotherapy Treatment	O	O	Hepatitis A,B,C	O	O	Stomach problems	O	O
Colitis / Chron's Disease	O	O	High Blood Pressure	O	O	Stroke	O	O
COPD	O	O	Joint Replacement	O	O	Thyroid problems	O	O
Congenital Heart Defect	O	O	Kidney Problems	O	O	Tobacco use	O	O
Diabetes	O	O	Leukemia	O	O	Tuberculosis	O	O
Difficulty breathing	O	O	Liver Disease	O	O	Ulcers	O	O
Drug abuse	O	O	Low Blood Pressure	O	O	Venereal Disease	O	O
Emphysema	O	O	Major Surgery	O	O			

If yes to any condition above, please describe:

_____

_____

_____

_____

Please list all current medications: