Oasis Dental
610 N. Mills Ave. Suite 200
Orlando, FL 32803
Phone: (407)674-8770

Welcome to Oasis Dental! Please fill out the following information for the staff to be able to get to know you. Thank you for becoming part of the family.

First Name:_____Last Name:_____Middle Initial_____

Preferred Name_____ Responsible Party Name (if under18)_____

Who may we thank for referring you?_____(Please ask about the special referral program)

Address_____Apt_____

City, State,
Zip:_____

Home Phone:_____Work Phone:_____ext_____

Cell Phone:_____Emergency Phone/Contact_____

Martial Status: ___Married ____Single____Divorced___Separated___Widowed

Birthdate:_____ Social Security:_____Drivers Lic:_____

Email:_____

Insurance Information:

Name of Insurance:_____Phone Number:_____Group number:_____

Address:_____Employer:_____

Please give card to front desk

Policy Holder Information: (if different from patient)

Name of insured:_____Relationship to Policyholder_____

Policy holder ID number or Social Security:_____D.O.B_____

Please Circle 'Yes' or 'No' if you have or had any of the following:

Aids/ Hiv	Yes	No
Alzheimer's Disease	Yes	No
Anaphylaxis	Yes	No
Anemia	Yes	No
Angina / Chest Pain	Yes	No
Arthritis/Gout	Yes	No
Artificial Heart Valve	Yes	No
Artificial Joint	Yes	No
Asthma	Yes	No
Blood Disease	Yes	No
Breathing Problem	Yes	No
Bruise Easily	Yes	No
Cancer	Yes	No
Chemotherapy	Yes	No
Cold Sores/ Fever Blisters	Yes	No
Congenital Heart Disorder	Yes	No
Cortisone Medicine	Yes	No
Diabetes	Yes	No
Drug Addiction	Yes	No
Easily Winded	Yes	No
Emphysema	Yes	No
Convulsions/Epilepsy/ Seizures	Yes	No
Excessive Bleeding	Yes	No
Excessive Thirst	Yes	No
Fainting Spells/ Dizziness	Yes	No
Frequent Cough	Yes	No
Frequent Diarrhea	Yes	No
Frequent Headaches	Yes	No
Glaucoma	Yes	No
Heart Attack/ Failure	Yes	No
Heart Murmur	Yes	No
Heart Trouble/ Disease	Yes	No
Hemophilia	Yes	No
Hepatitis A,B, or C	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Hives or Rash	Yes	No
Hypoglycemia	Yes	No
Irregular Heartbeat	Yes	No
Kidney Problems	Yes	No
Leukemia	Yes	No
Liver Disease	Yes	No
Low Blood Pressure	Yes	No
Lung Disease	Yes	No
Mitral Valve Prolapse	Yes	No
Osteoporosis	Yes	No
Pain in Jaw Joint	Yes	No
Parathyroid Disease	Yes	No
Psychiatric Care	Yes	No
Radiation Treatments	Yes	No
Recent Weight Loss	Yes	No
Rheumatic Fever	Yes	No
Rheumatism	Yes	No
Scarlet Fever	Yes	No
Shingles	Yes	No
Sickle Cell Disease	Yes	No
Sinus Trouble	Yes	No
Spina Bifida	Yes	No
Stomach/Intestinal Disease	Yes	No
Stroke	Yes	No
Swelling of Limbs	Yes	No
Thyroid Disease	Yes	No
Tonsillitis	Yes	No
Tuberculosis	Yes	No
Tumors or Growths	Yes	No
Ulcers	Yes	No
Venereal Disease	Yes	No
Jaundice	Yes	No

Women:

Pregnant/ Trying	Yes	No
Nursing	Yes	No
Taking oral contraceptives	Yes	No

Allergic to:

Aspirin	Yes	No
Penicillin	Yes	No
Codeine	Yes	No
Local Anesthetics	Yes	No
Acrylic	Yes	No
Metal	Yes	No
Latex	Yes	No
Sulfa Drugs	Yes	No

Other_____

Please Sign and Date: x_____ x_____

Medical History

It is very important to inform the dental staff of any medical conditions or medications taken. Please fill out the following as best you can. If you check 'Yes' to a question please explain. Thank You!

1) Are you under a physician's care now? Yes No – If yes please explain:_____
2) Have you ever been hospitalized or had a major operation? Yes No –if yes please explain:_____
3) Have you ever had a serious head or neck injury? Yes No—if yes please explain:_____

4) Are you taking any Medications, Pills,Drugs, over the counter medicines(including Aspirin)? Yes No ---**If Yes Please write down all names and amounts:**_____
_____
_____
If you have a list already written give to front desk.

5) Do you take, or have you taken,Phen-Fen or Redux? Yes No---if yes please explain:_____

6) Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No—If yes please explain:_____

7) Are you on a special Diet? Yes No—If yes please explain:_____

8) Do you use tobacco/tobacco products? Yes No—If yes please explain:_____

9) Do you use recreation drugs? Yes No—If yes please explain:_____

10) Are you taking any vitamins or natural supplements? Yes No—if yes please explain:-
_____

Please Sign_____Date_____