

**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 \_\_\_\_\_

Marital 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	Lung Disease	Yes	No
Alzheimer's Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Anaphylaxis	Yes	No	Osteoporosis	Yes	No
Anemia	Yes	No	Pain in Jaw Joint	Yes	No
Angina / Chest Pain	Yes	No	Parathyroid Disease	Yes	No
Arthritis/Gout	Yes	No	Psychiatric Care	Yes	No
Artificial Heart Valve	Yes	No	Radiation Treatments	Yes	No
Artificial Joint	Yes	No	Recent Weight Loss	Yes	No
Asthma	Yes	No	Rheumatic Fever	Yes	No
Blood Disease	Yes	No	Rheumatism	Yes	No
Breathing Problem	Yes	No	Scarlet Fever	Yes	No
Bruise Easily	Yes	No	Shingles	Yes	No
Cancer	Yes	No	Sickle Cell Disease	Yes	No
Chemotherapy	Yes	No	Sinus Trouble	Yes	No
Cold Sores/ Fever Blisters	Yes	No	Spina Bifida	Yes	No
Congenital Heart Disorder	Yes	No	Stomach/Intestinal		
Cortisone Medicine	Yes	No	Disease	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
Drug Addiction	Yes	No	Swelling of Limbs	Yes	No
Easily Winded	Yes	No	Thyroid Disease	Yes	No
Emphysema	Yes	No	Tonsillitis	Yes	No
Convulsions/Epilepsy/ Seizures	Yes	No	Tuberculosis	Yes	No
Excessive Bleeding	Yes	No	Tumors or Growths	Yes	No
Excessive Thirst	Yes	No	Ulcers	Yes	No
Fainting Spells/ Dizziness	Yes	No	Venereal Disease	Yes	No
Frequent Cough	Yes	No	Jaundice	Yes	No
Frequent Diarrhea	Yes	No			
Frequent Headaches	Yes	No	<b><u>Women:</u></b>		
Glaucoma	Yes	No	Pregnant/ Trying	Yes	No
Heart Attack/ Failure	Yes	No	Nursing	Yes	No
Heart Murmur	Yes	No	Taking		
Heart Trouble/ Disease	Yes	No	oral contraceptives	Yes	No
Hemophilia	Yes	No			
Hepatitis A,B, or C	Yes	No	<b><u>Allergic to:</u></b>		
Herpes	Yes	No	Aspirin	Yes	No
High Blood Pressure	Yes	No	Penicillin	Yes	No
High Cholesterol	Yes	No	Codeine	Yes	No
Hives or Rash	Yes	No	Local Anesthetics	Yes	No
Hypoglycemia	Yes	No	Acrylic	Yes	No
Irregular Heartbeat	Yes	No	Metal	Yes	No
Kidney Problems	Yes	No	Latex	Yes	No
Leukemia	Yes	No	Sulfa Drugs	Yes	No
Liver Disease	Yes	No	Other _____		
Low Blood Pressure	Yes	No			

**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, Phenylenedramine or Redoxon? 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 \_\_\_\_\_

