PREMIER DENTAL
"BUILDING FAMILY ONE PATIENT AT A TIME"
DR. CHAD M. REID, D.D.S.

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Coweta, OK 74429
918-279-7100

PATIENT INFORMATION

First Name_____Last Name_____Preferred Name_____
Date of Birth_____Social Security No._____Sex M____F____
Address_____City_____State_____Zip Code_____
Home No._____Work No._____Cell No._____
E-Mail_____
In case of emerency: Name_____Phone No._____

How did you hear about Premier Dental? Newspaper, Yellow Pages, Website, Banner, Friend_____, Insurance Provider, Mailer, Other_____.

PARENTS INFORMATION
(Only if patient is a minor child)

First Name_____Last Name_____Preferred Name_____
Date of Birth_____Social Security No._____Sex M____F____
Address_____City_____State_____Zip Code_____
Home No._____Work No._____Cell No._____

INSURANCE INFORMATION

Subscriber's Name_____
Subscriber's Address_____
Subscriber's Date of Birth_____Social Security No._____
Employer's Name_____Phone No._____
Insurance Company_____Phone No._____
Group No._____Subscriber's ID_____

DENTAL HISTORY

Do you have a specific dental problem? Y____N____(If yes, explain)_____
Do you Smoke___Dip___Chew___Get mouth sores___ Do you brush and floss daily? Y____N____
Do you clinch or grind your teeth? Y____N____ Do you get routine dental exams? Y____N____
Does your jaw ever pop or cause you any discomfort? Y____N____(If yes, explain)_____
Have you ever had a bad dental experience? Y____N____(If yes, explain)_____
Do you like the appearance of your teeth? Y____N____ Do your gums ever bleed? Y____N____
Are you bothered by missing teeth? Y___N___Would you like whiter teeth? Y____N____
Are you satisfied with the chewing function of your teeth? Y____N____
Name of previous Dentist_____Last dental exam_____

MEDICAL INFORMATION

Name of your Physician_____Phone No._____
Have you had any serious illness, operation or been hospitalized in the past 5 years? Y____N____
If yes, explain_____
Are you taking any medications? Y____N____(If yes, explain)_____
Are you allergic to Latex____Penicillin____Codeine____Sulfa____Amoxicillin____Aspirin____
Are you allergic to anything not listed above? Y____N____(If yes, explain)_____

Women

Are you pregnant Y____N____ Trying to get pregnant Y____N____ Nursing Y____N____
Taking oral contraceptives Y____N____

HEALTH HISTORY

Do you have/had any of the following?

AIDS Y___N___	Fainting/Dizziness Y___N___	Lung Disease Y___N___
Allergies/Hay Fever Y___N___	Glaucoma Y___N___	Mental Disorders Y___N___
Alzheimer's Y___N___	Head Injuries Y___N___	MVP Y___N___
Anemia Y___N___	Heart Disease Y___N___	Need Premedication Y___N___
Arthritis Y___N___	Heart Failure Y___N___	Nervousness Y___N___
Artificial Joints Y___N___	Heart Murmur Y___N___	Pace Maker Y___N___
Asthma Y___N___	Hepatitis Y___N___	Radiation Treatment Y___N___
Blood Disease Y___N__	High Blood Pressure Y___N___	Respiratory Problems Y___N___
Blood Transfusion Y___N___	HIV Y___N___	Rheumatic Fever Y___N___
Bruise Easily Y___N___	Hypoglycemia Y___N___	Rheumatism Y___N___
Cancer Y___N___	Irregular Heartbeat Y___N___	Sinus Problems Y___N___
Chemotherapy Y___N___	Jaundice Y___N___	Stroke Y___N___
Congenital Heart Disorder Y___N___	Kidney Disease Y___N___	Thyroid Disease Y___N___
Convulsions Y___N___	Leukemia Y___N___	Tuberculosis Y___N___
Diabetes Y___N___	Liver Disease Y___N___	Tumors Y___N___
Epilepsy/Seizures Y___N___	Low Blood Pressure Y___N___	Ulcers Y___N___

Have you ever taken Fosamax or any other Osteoporosis medications? Y___N___

Do you have any serious illness not listed above?_____

I certify that I have read and I understand the questions above and that I have answered them to my satisfaction. I give Dr. Chad Reid authorazation to do any dental work that needs to be and I will not hold Dr. Chad Reid or any member of his staff responsible for any errors I have made in the completion of this form. I understand that Dr. Chad Reid makes every effort to keep the cost of dental treatment down and I will do my part by paying any deductible, co-pay or outstanding balance I may have upon completion after each dental visit. I give Dr. Chad Reid authorazation to release any information necessary to my dental insurance company in order to file any claims. I do understand that dental insurance is a method of reimbursing Dr. Chad Reid for his dental services and is not a guarantee of payment or a substitution of payment.

Signature of Patient_____Date_____
(Parent/Guardian if Patient is a minor)